Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board Meeting in Public
7 July 2022

Agenda and papers

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Trust Board Meeting in Public
Agenda

Date and Time: **Thursday 7 July 2022, 10:00 – 12:10**
Venue: **Tooting and Balham Rooms, Wandsworth Professional Development Centre, Building 1, Burntwood School, Burntwood Lane, SW17 0AQ**

Time	Item	Subject	Lead	Action	Format
1.0 OPENING ADMINISTRATION					
10:00	**1.1**	**Welcome and apologies**	**Chairman**	Note	Verbal
	1.2	**Declarations of interest**	**All**	Note	Verbal
	1.3	**Minutes of previous meeting**	**Chairman**	Approve	Report
	1.4	**Action log and matters arising**	**All**	Review	Report
10:05	**1.5**	**Group Chief Executive Officer's Report**	**GCEO**	Inform	Report
2.0 CARE					
10:15	**2.1**	**Quality Committee Report**	**Committee Chair**	Assure	Report
10:25	**2.2**	**Learning from Deaths Q4 2021/22 Report***	**GCMO**	Assure	Report
10:35	**2.3**	**Integrated Quality and Performance Report***	**MD-SGUH**	Assure	Report
		2.3.1 Breast Recovery Update	**MD-SGUH**	Assure	Report
3.0 CULTURE					
10:55	**3.1**	**People Committee Report**	**Committee Chair**	Assure	Report
4.0 COLLABORATION					
11:05	**4.1**	**Audit Committee Report**	**Committee Chair**	Assure	Report
11:15	**4.2**	**Finance Committee Report**	**Committee Chair**	Assure	Report
11:25	**4.3**	**Finance Report (Month 2)***	**GCFO**	Review	Report
11:30	**4.4**	**Board Assurance Framework Q1 2022/23***	**GCCAO**	Review	Report
5.0 CLOSING ADMINISTRATION					
11:40	**5.1**	**Questions from Governors and Public**	**All**	Note	Verbal
	5.2	**Any new risks or issues identified**	**All**	Note	
	5.3	**Any Other Business**	**All**	Note	
	5.4	**Draft Agenda for Next Meeting**	**Chairman**	Note	Report
11:50	**5.5**	**Patient Story**	**GCNO**	Inform	Verbal
12:10	**CLOSE**				

Date of Next Meeting: Thursday 1 September 2022

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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NHS
St George's University Hospitals
NHS Foundation Trust

Trust Board
Purpose, Meetings and Membership

Trust Board Purpose:	The general duty of the Board of Directors and of each Director individually, is to act with a view to promoting the success of the Trust so as to maximise the benefits for the members of the Trust as a whole and for the public.

Membership and Attendees		
Members	**Designation**	**Abbreviation**
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director/Vice Chairman	AB
Stephen Collier	Non-Executive Director	SC
Paul da Gama	Group Chief People Officer	GCPO
Andrew Grimshaw	Group Chief Finance Officer	GCFO
Jenny Higham	Non-Executive Director (St George's University Representative)	JH
Richard Jennings	Chief Medical Officer	GCMO
Stephen Jones	Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Dame Parveen Kumar	Non-Executive Director	NED
Pui-Ling Li	Associate Non-Executive Director	ANED
James Marsh	Group Deputy Chief Executive Officer	GDCEO
Kate Slemeck	Managing Director – St George's	MD-SGUH
Tim Wright	Non-Executive Director	NED
Arlene Wellman	Group Chief Nursing Officer	GCNO
In Attendance		
James Blythe	Managing Director – Epsom and St Helier	MD-ESTH
Anna Macarthur	Director of Communications and Engagement	DCE
Patricia Morrissey	Head of Corporate Governance	HoCG
Thirza Sawtell	Managing Director – Integrated Care	MD-IC
Apologies		
Quorum:	*The quorum of this meeting is a third of the voting members of the Board which must include one non-executive director and one executive director.*	

These reports were reviewed, discussed and endorsed by the relevant Board Committees and the Committee provided an assurance overview in the reports to the Board.

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NHS
St George's University Hospitals
NHS Foundation Trust

Minutes of the St George's University Hospitals NHS Foundation Trust Board Meeting in Public

Thursday 5 May 2022

Held virtually via Microsoft Teams

PRESENT		
Gillian Norton	Chairman	Chairman
Jacqueline Totterdell	Group Chief Executive Officer	GCEO
Ann Beasley	Non-Executive Director	AB
Stephen Collier	Non-Executive Director	SC
Andrew Grimshaw	Chief Finance Officer and Deputy Chief Executive Officer	GCFO
Prof Jenny Higham	Non-Executive Director	JH
Dr Richard Jennings	Group Chief Medical Officer	GCMO
Stephen Jones*	Group Chief Corporate Affairs Officer	GCCAO
Peter Kane	Non-Executive Director	PKa
Dr Pui-Ling Li*	Associate Non-Executive Director	PL
Kate Slemeck*	Managing Director – St George's	MD-SGUH
Tim Wright	Non-Executive Director	TW
IN ATTENDANCE		
Anna Macarthur	Director of Communications and Engagement	DCE
Geoff Stokes	Head of Corporate Governance/Board Secretary (minutes)	HoCG
Stephanie Sweeney	Acting Chief Nurse, St George's (for GCNO)	CN
APOLOGIES		
Paul Da Gama*	Group Chief People Officer	CPO
Prof Parveen Kumar	Non-Executive Director	PKu
Dr James Marsh	Group Deputy Chief Executive Officer	GDCEO
Thirza Sawtell*	Managing Director – Integrated Care	MD - IC
Arlene Wellman	Group Chief Nursing Officer	GCNO

** Non-voting members of the Board*

		Action
1.0	**OPENING ADMINISTRATION**	
1.1	**Welcome, introductions and apologies**	
	The Chairman welcomed everyone to the meeting which was the first meeting in person since the start of the pandemic. The apologies above were received and noted. There had been a change in the meeting cycle for 2022/23 with the Board now meeting on the first Thursday of each month and this change meant that meeting coincided with pre-existing annual leave of some directors.	
1.2	**Declarations of Interest**	
	The standing interests in relation to the shared roles with Epsom and St Helier University Hospitals NHS Trust (ESTH) of the following directors was noted, which have previously been authorised by the Board: • Gillian Norton as Chairman-in-Common; • Ann Beasley and Peter Kane as non-executive directors; • Jacqueline Totterdell, Andrew Grimshaw, Richard Jennings and Stephen Jones, as executive directors. Ann Beasley also declared her interest as Chair of South West London and St George's Mental Health NHS Trust.	
1.3	**Minutes of the Previous Meeting**	
	The minutes of the meeting held on 31 March 2022 were approved as a true and accurate record.	
1.4	**Action Log and Matters Arising**	
	The Board reviewed and noted the action log and approved action **TB220331.1** for closure as the update on breast cancer performance has been added to the agenda for 7 July 2022.	
1.5	**Group Chief Executive's Officer (GCEO) Report**	
	The Board received the report from the GCEO, who made the following points: • The hospital is still very busy, especially in the emergency department (ED). • St George's is 100% compliant with the 'immediate and essential actions' from the Ockenden review and an assurance visit from the Regional Chief Midwife is planned for 12 May 2022. • There is growing recognition by system partners of the importance of the Trust's paediatrics cancer services in the wider system landscape. • In relation to the new Group structure, appointments have been made to the posts of Director of Integration, Director of Performance, Director of Quality Improvement and Director of Strategy, which report into the Group Deputy Chief Executive Officer.	

		Action
	• Congratulations are due to Arlene Wellman, Group Chief Nursing Officer, who received her MBE from the Prince of Wales at Windsor Castle on 4 May 2022. • Congratulations are also due to Jenni Doman, Deputy Director of Estates and Facilities, who has been nominated for Leader of the Year in the Health Estates and Facilities Management Association (HEFMA) awards.	
	PKa welcomed the positive position of the Trust in relation to Ockenden and asked how that message can be shared with prospective mothers to reassure them about the quality of care given by the Trust. The GCEO agreed that would be helpful but felt that this should wait until the outcome of the assurance visit takes place. It was noted, however, that the helpline set up by the Trust has been well received by prospective parents.	
	PKa also asked about the cumulative impact of the various operational and financial pressures the Trust, and wider system, faces. The GCEO emphasised that patient care is the most important focus for the Trust and we are working closely with the London Ambulance Service and local partners to alleviate pressure. The Chairman added that in relative terms the Trust is doing well, but there are significant pressures facing all parts of the South West London system and across the country.	
	TW added that a recent survey highlighted St George's Charity as one of the most popular 'brands' in the sector.	
	The Board noted the Group Chief Executive Officer's report.	
2.0	**CARE**	
2.1	**Quality and Safety Committee Report** in the absence of the Chair of the Committee, Professor Dame Parveen Kumar, Pui Ling Li, Associate Non-Executive Director, presented the report of the meeting held in April 2022, which was the first held as a committee-in-common with Epsom and St Helier University Hospitals NHS Trust (ESTH). The report set out the key matters raised and discussed, and it was noted that some of the reports received by the Committee also feature later on the Board agenda. The key matters of note from the Committee related to: • Compliance with staff undertaking life support training continues to be challenging and compliance was not yet where it needed to be. • Performance in responding to complaints continues to be good with 100% of cases closed within the established timescales. • One of the serious incidents reported was a sad case of a suicide and although there were no obvious errors or omissions and there was effective working with mental health service partners it was important the SI investigation examines whether all was done that could have been done. • The serious incident report into the Covid-19 outbreak in Amyand Ward highlighted the need for ventilation and the consequences of caring for patients in an aging building.	

		Action
	• Compliance with addressing issues raised by the Ockenden is good and the assurance visit is awaited. AB noted her interest as chair of South West London and St George's Mental Health NHS Trust and confirmed that relationships between both trusts are very good and acknowledged that assessments of patients may not always identify those who have a serious suicidal ideation. PLL agreed that the assessment process will not pick up all cases. AB also queried the 'wrong site surgery' never event and what early learning has been identified. PLL responded that new protocols have been put in place to use photographs in theatre and speak to the patient about their surgery immediately before a procedure. The GCMO added that all wrong site surgery never events in the last few years have highlighted the need for the World Health Organisation (WHO) checklist to be mirrored in local safety standards for invasive procedures (LOCSSIPS). He added that skin is a vulnerable area for 'wrong site surgery' never events, and although patients suffered minimal harm, lessons need to be learned. The GCMO also noted that Covid-19 related absence has partly explained the non-attendance at life support training. PKa asked about performance against cancer standards and the MD-SGUH explained that the Trust is well ahead of the required trajectory to achieve the 62 day standard by the end of the year. PKa also asked whether visitor restrictions have been lifted for inpatients. The CN noted that restrictions on inpatient visiting have been relaxed to a degree. The MD-SGUH added that there are still restrictions in relation to outpatients due to space availability. The Board noted the updates from the April 2022 Committee meeting.	
2.2	**Integrated Quality and Performance Report (IQPR)** The Board received and noted the IQPR for month 12 (March 2022), which had been scrutinised at both the Finance Committee and Quality Committee the previous week. Operational highlights were as follows: • ED performance continues to be a pressure impacting on ambulance handover rates and is largely driven by the availability of beds. • Length of stay has increased as the patients being admitted are more poorly. • Covid-19 rates amongst both patients and staff have impacted on the availability of beds in the Trust. • There are capacity issues at the Urgent Treatment Centre (UTC) which have had a knock impact to ED. • Sundays are the lowest day for discharges of inpatients causing issues on Mondays as backlogs are cleared. • Elective lists have plateaued so backlogs are not reducing as quickly as required.	

		Action
	• Theatre capacity has increased at Queen Mary Hospital (QMH) and through utilisation of the day surgery unit. • There is a trial in ear, nose and throat (ENT) and general surgery to text patients on waiting lists to ensure they still require their treatment. • Outpatient activity is above trajectory but there is a struggle to keep up with the increasing demand. • Diagnostics performance has improved to only 1.7% of patients not being seen within timelines against the target of 1%. • Cancer performance is seeing the backlog reduce to 127 from 180 which is an indicator that performance rates will improve for April. • Sickness levels are improving, due to a 50% reduction in Covid-19 related absence. • Both medical and non-medical appraisal rates need to improve.	
	SC welcomed the improvement in theatre utilisation and that some of the efficiency projects are succeeding. He asked whether recovery is on track. The MD-SGUH noted that performance is currently behind recovery trajectories and work continues with partners in south-west London. She added that activity and demand are also increasing but that trajectories should be met by the end of the year. The GCEO added that she has raised the concern that low-volume, high complexity work at tertiary sites like St George's will remain if there is too much focus on volume. SC acknowledged the difficulty of scheduling some complex cases which can take all or most of the day within a theatre.	
	JH noted that many of the problems emerging were prevalent before the pandemic and that discharge relies on sector partners and their capacity. The MD-SGUH noted that there are good working relationships with local authorities.	
	In response to a question from TW, the MD-SGUH explained that greater use of virtual wards will help to discharge patients more quickly.	
	The Board noted the IQPR report.	
2.3	**Maternity Services Update Following Publication of the Ockenden Report**	
	Stephanie Sweeney, Site Chief Nurse, introduced the report and the following points were made: • In December 2020, NHS England and NHS Improvement (NHSE/I) published requirements for action to be taken against the 15 'immediate and essential actions' (IEAs) identified in the draft Ockenden report by February 2021. • The final report was published in March 2022 with further requirements which are being addressed. • St George's is 100% compliant against the IEAs. • The Regional Chief Midwife for the NHS is due to visit the Trust next week to review maternity services and an assurance report is due two weeks later.	
	PKa welcomed the compliance against the IEAs and asked how this will be monitored moving forward. The CN explained that these metrics will be	

		Action
	included in a dashboard which will be regularly reported at the Quality Committee.	
	PKa also asked about the learning from SGUH that can be shared with ESTH and vice versa. The CN explained that the Heads of Midwifery at both trusts work closely together. The GCEO added that ESTH performance is good and there is strong collaboration between both trusts.	
	TW asked about staffing and the CN explained that there are currently 22 midwife vacancies, of which 21 have been recruited to and will start in June. Funding has been committed to address other vacancies in maternity.	
	TW also asked about the rates of caesarean sections and expressed surprise that they were relatively low given the complexity of cases the Trust deals with. The GCMO commented that the issue raised in the Ockenden report about mothers coming under pressure to opt for vaginal delivery even if a c-section was more appropriate is not the case at St George's.	
	AB asked about the progress being made on understanding differential rates for mothers of different ethnicities. The GCMO commented that this is an area in which SGUH can learn from ESTH where that information is very well collated.	
	The GCEO commented that the leadership of maternity services given by Janet Bradley, Director of Midwifery, and Gynaecology Outpatient Nursing is exemplary and has helped to get maternity services in a positive place.	
	The Board noted: • the progress made to date and compliance against the 'immediate and essential actions' and • the external annual assurance process and internal and external governance. In addition, the Board delegated to the Quality Committee, in consultation with the GCEO and Chairman, review of the Continuity of Care return that is required to be made by 15 June 2022.	
3.0	**COLLABORATION**	
3.1	**Finance Committee Report**	
	Ann Beasley, Chair of the Committee, provided an update on the meeting held in April 2022 and highlighted the following: • This was also the first committee-in-common and the terms of reference were discussed with a revised set to be presented for approval later in the meeting. • A report on cancer recovery trajectory has been requested. • The Trust is the first to achieve a carbon-neutral menu for patients. • The risks around IT were discussed and a change in risk scoring for SR3 – ICT and Operational Risk, was proposed and will be addressed later in the agenda.	

		Action
	• The Committee expressed concern about the lateness of the operational planning process for 2022/23 and the size of the gap against the targets set nationally. The Board noted the report.	
3.2	**Finance Performance Report Month 12**	
	Andrew Grimshaw, Group Chief Finance Officer (GCFO), presented the report and provided the following updates: • The year-end had ended against plan and the cash position is healthy, although this relates to covid funding. • There has been late notification of income by NHSE/I which has improved the year-end position slightly.	
	TW asked about cost improvement programmes (CIPs) and how the Trust will return to targeting these given their suspension during the pandemic. The GCFO agreed that engaging the organisation in identifying and delivering CIPs and transformational change is a challenge but this is being addressed. The MD-SGUH added that some of the additional costs that have been incurred during the pandemic are not easily reversed.	
	The Board noted the financial performance as per the final accounts' submission on 26 April 2022.	
3.3	**Board Assurance Framework Q4 2021/22 Report**	
	Stephen Jones, Group Chief Corporate Affairs Officer (GCCAO), introduced the Board Assurance Framework (BAF) quarter 4 2021/22 report, and the following points were made about strategic risks (SRs):	
	• SR2 (safe and effective care) – The Quality and Safety Committee proposed a reduction in risk score from 12 to 8 due to the implementation of the clinical governance improvement plan which had addressed the recommendations of the three-part independent clinical governance review. • SR7 (estates) – The Finance and Investment Committee recommended a reduction in risk score from 20 to 16 due to a number of improvements made to the Trust's estate. • SR9 (workforce) – the risk score had been increased in response to the plans to implement vaccination as a condition of deployment (VCOD) but following the reversal of the government's plans, Workforce and Education Committee proposed that the risk score be reduced to 16. • SR4 (system working) – it was noted that there are inherent risks within the system so the recommendation is that the risk score remains at 12. • Assurance has improved in five of the ten strategic risks.	
	JH asked whether the same conversations are happening at ESTH and the GCCAO explained that currently the BAF and the processes for scrutiny are different at ESTH compared with SGUH. He will be working on aligning the processes in both trusts.	

		Action
	PKa asked about the system risk and whether the passing of the Health and Care Act 2022 by Parliament will be helpful. The GCEO explained that there will need to be a development at ICS level to review strategic risks across the system and the extent to which they add value. The development of the public health agenda is particularly important at system level and there is not yet the necessary understanding of the need for research and education.	
	The Chairman added that the key question is how the ICS/ICB adds value especially given the strength of the provider collaborative in south west London.	
	The Chairman concluded by stating that the Trust is in a much better place in relation to the BAF than when she joined the Trust as Chairman.	
	The Board made the following resolutions: a) For the SR4 (system working) which is reserved to itself: ○ Agreed the proposed score of 12 (4C x 3L) (no change) ○ Agreed the proposed assurance rating of 'good' (no change) b) For the remaining 9 strategic risks assigned to its committees: ○ Agreed the proposed risk scores, assurance ratings and statements from the relevant assuring committee. ○ Noted the progress achieved in year in mitigating identified gaps in control and assurance.	
4.0	**GOVERNANCE**	
4.1	**Group Governance Arrangements**	
	Stephen Jones, Group Chief Corporate Affairs Officer (GCCAO), presented the report and the following points were made: • The Group has developed well over the last few months and new governance arrangements for the Group had been developed in discussion with the two boards. • It is important to recognise that SGUH and ESTH remain separate legal entities and this fact is material to the design of the governance arrangements. • Both boards will continue to meet separately during the first year of the Group but will meet collectively for board development sessions. • Committees-in-common have been formed for quality, finance and people issues. • The Memorandum of Understanding (MoU) and Information Sharing Agreement (ISA) have been drafted to provide a framework under which both trusts can collaborate effectively.	
	TW noted the issues related to security management and praised the quality of the report. He asked how success of the collaboration of the trusts will be measured. The GCCAO agreed that success measures would be helpful but will need to be developed and this may be helpfully addressed through the development of the Group strategy.	

		Action
	PKa noted that both trusts retain separate audit committees and expressed a view that there should be a move towards a committee-in-common for audit in 2023/24. The GCCAO noted that, particularly in the first year of the Group, it is important that both boards receive separate assurance on governance processes, internal control and risk so it is right to keep those separate at the moment, but as internal and external audit arrangements are aligned there will be scope for moving to a committee-in-common.	
	The Chairman commented on paragraph 3.2 of the ISA related to data sharing and processing and whether the requirements will be carried out in both trusts. The GCCAO agreed that this will be a requirement and will be monitored.	
	The Chairman thanked the GCCAO for the work he has carried out on this complicated piece of work.	
	The Board; a) approved the proposed group governance arrangements, including plans to establish committees-in-common for quality, finance and people across the two trusts, and approve the terms of reference and 2022/23 annual business plan for the Quality Committee, and the terms of reference for the Finance Committee; b) Noted that the terms of reference and 2022/23 annual business plan for the People Committee will be presented to the Board for consideration following review by the respective trust committees later this month. c) Approved the Memorandum of Understanding to provide a framework for closer collaboration between the two organisations which will be achieved through the formation of the Group; d) Approved the Information Sharing Agreement to provide a framework through which the two sovereign Trusts can share information for the purposes of the Group as set out in the MoU; e) Noted that, subject to the approval of these proposals, the Standing Orders, Scheme of Delegation and Standing Financial Instructions for both Trusts will be reviewed with reference to the new Group arrangements.	
4.2	**Use of Trust Seal**	
	The Board received and noted the Use of the Trust Seal report.	
4.3	**Annual Self Certification NHS Foundations Trust License**	
	The Board received and noted the Annual Self Certification against the NHS Foundation Trust License. There is a standard requirement to publish the self-certification.	
	The majority of the Council of Governors have approved the statement in relation to governor training although one governor has not given their support to the statement.	
	AB asked about the statement regarding resources and whether it was possible to agree a nuanced position given there is not yet an agreed budget. The GCCAO explained that the compliance declaration is binary and covers all resources, not just financial, and is consistent with decisions made previously. The GCFO added the key word in this context is ‘reasonable’ and feels it is	

		Action
	appropriate that the Board approve the declaration noting the current uncertainty of the position.	
	The Board reviewed the self-certification against each of the licence conditions, including the proposed response in each area. This certification will be uploaded to the Trust's website by 30 June 2022, subject to any comments from Audit Committee.	
5.0	**CLOSING ADMINISTRATION**	
5.1	**Questions from Governors and the public** No questions were received from the public.	
	Any new risks or issues identified There were no other risks or issues identified.	
	Any Other Business No other business was raised.	
Date of next meeting: Thursday, 7 July 2022, Tooting and Balham Rooms, Wandsworth PDC, Building 1. Burntwood School. Burntwood Lane, SW17 0AQ		

The meeting closed at 12:10

Outstanding care every time

Trust Board (Public) - 7 July 2022

NHS
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NHS Foundation Trust

Action Log

ACTION REFERENCE	MEETING DATE	ITEM NO.	ITEM	ACTON	WHEN	WHO	UPDATE	STATUS
There are no open actions on the Action Log								

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NHS
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Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No.**	**1.5**
Report Title:	**Chief Executive Officer's Report**		
Lead Director/ Manager:	Jacqueline Totterdell, Chief Executive		
Report Author:	Jacqueline Totterdell, Chief Executive		
Presented for:	Assurance		
Executive Summary:	Overview of the Trust activity since the last Trust Board Meeting.		
Recommendation:	The Board is requested to receive the report for information.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All		
Single Oversight Framework Theme:	All		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A

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CEO Board Report July 2022

It has been a challenging period for the Trust since my last report to the Board in May. We declared two incidents to help us respond to the challenges we faced. We have also seen additional pressure from hot weather, an increase in Covid patients and we are caring for people with Monkey Pox.

In May an infrastructure failure in our emergency department meant we needed to close part of the area while remedial works were completed. But we were able to continue responding to blue light emergencies such as heart attacks, stroke and major trauma. While on 21 June, high volumes of patients led to a serious bed shortage and delays for patients who needed to be admitted. By working with the system, we were able to shift the position significantly within hours.

Effective teamwork and communication is at the heart of responding to any critical incident. The Trust has tried and tested procedures in place working with our partners and other NHS organisations to co-ordinate strategic, tactical, and organisational response plans for incidents and we used these effectively.

The Trust also took the opportunity to refine and develop its business continuity and critical incident protocols to make sure that our responses continue to be resilient, effective and timely.

Covid admissions in our hospital have increased slightly in June with 91 Covid positive patients in the hospital on 22 June. Thanks to the vaccination programme and better treatments, only two patients required ITU admission. We are now trying to keep Covid patients in their speciality where they will receive better care.

We have also seen a rise in cases of Monkeypox across the UK with most in London. St George's hosts the regional Infectious Diseases unit and is supporting the clinical diagnosis and management of cases in South West London. At the end of June we only had one inpatient with Monkeypox and were managing 22 patents at home on our new virtual ward.

Changes to mask wearing guidance in hospitals

We continue to monitor and revise our infection control guidance for staff and the public in line with national NHS advice and the Government's Living with Covid-19 plan.

We, along with many other Trusts, recently changed our guidance on wearing masks in our hospitals. Except for a few areas where we are treating vulnerable patients (such as wards/rooms with confirmed Covid positive patients) staff and members of the public are no longer required to wear a mask unless they wish to. Areas where masks are still required will be clearly signposted, and masks will be provided on entry for those who do not have one.

We are of course continuing to keep an eye on the local and national Covid picture and will make any further changes necessary, as and when they are required.

Mitie strikes

Around 30 Mite staff - who are part of the GMB Union - held industrial action on 30 May, 6 and 7 June and 20 – 26 June. The strikes came about due to complications with Mitie's staff pay cycle when it changed from every four weekly to monthly. Mitie have confirmed this has now been communicated, discussed with the teams and rectified.

We encouraged members of the public to continue accessing our hospital care throughout the strikes while Mitie staff – including cleaners and caterers – took action. Additional resources were put in place to support teams during this time to continue to provide services safely and mitigate any disruption. Thanks to everyone involved, clinical services remained unaffected and there were no issues with maintaining high standards of cleanliness and hygiene.

St George's is around two years into a 10-year contract with Mitie, and there are no plans to cut this short as some GMB protestors requested.

We have offered to facilitate talks between Mitie and GMB but this was declined by the union. Mitie staff are a hugely valued and key part of the St George's team, and we hope Mitie and GMB are able to come to a resolution very soon.

Finance

The Board is aware that that we have committed to tackle financial deficit and to end the year in a balanced financial position. That is the requirement from the national NHS for all Trusts for 22/23. There are many reasons behind the underlying financial challenges for example cost improvement programmes were paused during Covid, we have decreased funding compared to pandemic levels and further cost pressures linked to capital and inflation.

The Trust is not alone in facing significant financial challenges, but it is expected that the Trust, along with the South West London ICS, face a more material financial challenge than most.

My CFO Andrew Grimshaw is working with other executive directors on the details of the actions we will need to take to reach a break-even financial position at the Trust and will keep the board informed.

There is no doubt that this will be challenging and all our staff will need to be involved. We will be developing an integrated strategic communications plan, working with Epsom and St Helier, looking at the best ways to engage and involve our staff to help us achieve our target.

Group strategy development

As you are aware, the Boards of St George's and Epsom and St Helier Trusts have agreed to develop a single Group strategy by March 2023 to give staff a common sense of direction and a clear set of priorities for the years ahead.
We are not starting from a blank page - both Trusts have existing strategies, against which they are making good progress. However, the impact of Covid, advances in technology, closer collaboration between local health organisations, and the creation of the Group, all mean that parts of both strategies need refreshing. The result will be one Group strategy that clearly sets out what the Trusts will do in common as a Group, as well as their separate roles and identities.

A key building block for the Group strategy will be engagement over the summer to generate analysis, proposals and options. This will take place with individual clinical and corporate services, all staff at both Trusts, patients, and external partners. This will inform which strategic ideas to pursue and build into a final strategy that benefits both Trusts and the communities we serve.

South West London Integrated Care System

July 1st is the go live date for South West London ICS and I will be attending its first Integrated Care Board on this day as the Acute Provider Collaborative lead. The ICS will take responsibility for health and care statutory responsibilities and have four purposes:

1. improving outcomes in population health and healthcare
2. tackling inequalities in outcomes, experience and access
3. enhancing productivity and value for money
4. supporting broader social and economic development

By working together, we can do more to support people to live healthier and happier lives and I am pleased to be able to play my part. For example, by working together, we will prevent ill-health; keep people independent for longer; and take action together to address the wider-determinants of health.

All over the country, in the poorest areas people have worse health and lower life expectancy than the people living in the richest areas. Our South West London ICS will focus on reducing these health inequalities or unfair differences in health in different groups within our six boroughs. I wish it every success for the future.

Fuller stocktake

In November, NHS CEO Amanda Pritchard, asked Dr Claire Fuller, CEO Designate of Surrey Heartlands ICS to lead a review to provide specific and practical advice to all ICSs, as they assume new statutory form, on how they can accelerate implementation of the primary care, out of hospital care and prevention ambitions in the NHS Long Term Plan in their own geographies.

Her review identified what is not working such as access and continuity, with frustrations shared by both patients and staff alike. What also emerged was a consensus on what we can do differently.

Published at the end of May, the Fuller Stocktake sets out a new vision for integrated primary care based on developing streamlined access to urgent care for those that need it, more personalised care from a team of professionals for those with complex care needs, and a proactive approach to prevention at greater scale. The report is backed by all ICS CEOs and led to a letter of commitment to the stocktake vision signed by all parties.

Sajid visit

I was very pleased to welcome Secretary of State for Health, Sajid Javid, and Stéphane Bancel, Chief Executive of Moderna to St George's this month. The visit coincided with an announcement that the government made regarding a £1bn deal with Moderna to build the country's first manufacturing centre for vaccines. Mr Javid and Mr Bancel were shown around our impressive Clinical Research Facility and St George's, University of London's Vaccine Institute by Professor Dan Forton, Dr Catherine Cosgrove, and Professor Paul Health who explained more about the work that they do including recent and current research trials being carried out – and they even had the opportunity to speak to patient who was there as part of a booster vaccine study. It was a fantastic visit and made me so very proud of our teams and the clinical excellence carried out at St George's.

International Nurses Day and International Day of the Midwife

In May we marked International Nurses' Day and also International day of the Midwife to recognise and celebrate the huge contribution our nursing and midwifery colleagues make. We held a range of events across the trust and our Group CNO Arlene Wellman wrote to all nurses and midwives to thank them for their contributions. We were also able to offer a free breakfast to our nurses and midwives and Arlene, Kate Slemeck and I were able to present awards, serve food and visit staff across the group on these two special days.

National Healthcare Estates and Facilities Day

In June we celebrated the first ever National Healthcare Estates and Facilities Day. A fantastic event was held where our estates and facilities teams showcased all the work they do, and prizes and awards were given out. These are teams that do so much for us, our patients, and visitors - and it was great to have a special day to say thank you.

St George's Hospital Charity

St George's Hospital Charity recently launched their new children's appeal, Time for a Change, in partnership with, AFC Wimbledon. I was very pleased to attend the launch event – a Gala dinner – which raised a staggering £286,000! All the money raised from the Time for a Change campaign will go towards helping to transform Children's Services and expand our Paediatric Intensive Care Unit at St George's hospital. It will make a real difference to our littlest patients, their families and the staff who care for them.

Pride

June is Pride Month, which celebrates LGBTQ+ people in all their diversity, raises awareness, and combats prejudice with education. At the beginning of the month, we raised our Pride Progress flag, and we also gave out NHS Rainbow badges and lanyards to anyone who makes a pledge to reduce inequalities and support LGBTQ+ people. There were also staff network events with talks, information, and a photography exhibition. I am personally looking forward to joining the Pride March event in central London on Saturday 1 July.

Awards

Finally, I would like to share news of two recent awards with the Board. Firstly, my congratulations to Professor Indranil Chakravorty – consultant in acute and respiratory medicine at St George's – who's been awarded an MBE for his contributions to healthcare as part of the Queen's platinum jubilee honours. Indranil is passionate about diversity and inclusion in healthcare, and has made an enormous contribution to medical education, and research into tackling health inequalities.

And I'm pleased to report that we were recently assessed by the Improving Quality in Liver Services (IQILS) programme run by the Royal College of Physicians. The aim of the programme is to improve the quality of medical liver services throughout the UK. Following our assessment we have received accreditation for the service.

Two pieces of good news and congratulations to the teams involved for all their hard work.

Meeting Title:	**Trust Board**		
Date:	**7 July 2022**	**Agenda No**	**2.1**
Report Title:	**Quality Committee Report**		
Lead Director/ Manager:	Prof. Dame Parveen Kumar, Chair of the Quality Committee		
Report Author:	Prof. Dame Parveen Kumar, Chair of the Quality Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues covered by the Quality Committee at its meetings in May and June 2022. The Committee has been operating as a Committee-in-Common with the Epsom and St Helier University Hospitals NHS Trust Quality Committee since April 2022. This report highlights only those issues related to St George's although some issues were relevant to both trusts.		
Recommendation:	The Board is asked to note the update from the May and June 2022 meetings of the Committee.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	All CQC domains		
NHS System Oversight Framework Theme:	Quality of care, Operational Performance, Leadership and Improvement Capability		
Implications			
Risk:	Relevant risks considered.		
Legal/Regulatory:	CQC Regulatory Standards		
Resources:	N/A		
Previously Considered by:	N/A	Date:	N/A
Appendices:	N/A		

Quality Committee Report
Trust Board, 7 July 2022

Matters for the Board's attention

The Quality Committee met on 19 May and 23 June 2022 its new form as a committee-in-common with the Quality Committee of Epsom and St Helier University Hospitals NHS Trust (ESTH). As the Board is aware, chairing of meetings of the Quality Committees-in-Common rotates between the respective chairs of the Committees at ESTH and SGUH. I chaired the May 2022 meeting and the ESTH Chair chaired the June 2022 meeting.

The Committee considered the following matters of business at these meetings:

May 2022	June 2022
• Quality Performance Report (M1)*	• Quality Performance Report (M2)*
• Serious Incidents Report	• Learning from Deaths Report Q4 21/22*
• Maternity Services Report	• Serious Incidents Report
• Infection Prevention and Control Report	• Maternity Services Report (inc. CNST Scheme for Maternity)
• Cardiac Surgery Report	• Infection Prevention and Control Report
• Clinical Audit Plan 2022/23	• Research and Development Strategy Implementation Report
• Inspections Update	• Patient Safety and Quality Group Report
• Draft Quality Account 2021/22	• Corporate Risk Register
• Patient Safety and Quality Group Report	• Board Assurance Framework*
• Board Assurance Framework*	• Deep Dive on group-wide performance, themes and learning from the Quality Account 2021/22

**These items are also presented to the Board for consideration at the May 2022 Board meeting.*

The report covers the key issues that the Committee would like to bring to the attention of the Board.

1. Quality Performance Report: Months 1 and 2 2022/23

The Committee considered the key areas of quality and safety performance in months 1 and 2 and would like to highlight the following issues, recognising that the Board will discuss the performance data at month 2 later on the agenda:

- Areas of challenge:
  - Basic life support (BLS), immediate life support (ILS) and advanced life support (ALS) training levels continued to be below target, despite improvements. A review of training needs of all staff would be completed by the end of June.
  - Compliance with appropriate response to Early Warning Scores (Adults) had fallen from 91.5% in April to 77.2% in May.
  - There had been one Never Event that had been declared in May which was currently being investigated. The Committee will review the details once the investigation is completed.

  - Mental Capacity Act and Deprivation of Liberty Standards (MCA/DoLs) level 1 training performance had deteriorated to 87.5% in May, though level 2 MCA/DoLs training levels had improved from 68.9% in April to 71.3% in May.
  - There had been 5 *C.difficile* cases in May in addition to the 13 cases in April, and the Trust was now above the trajectory set by NHS England.
  - Positive Friends and Family Survey responses for the emergency department had fallen from 72% in April to 68.3% in May against a target of 90%. The responses continued to be impacted by the significant operational pressures on ED and increased waiting times.
- Areas of good or improving performance:
  - The percentage of inpatient Treatment Escalation Plans (excluding paediatrics and maternity) had reached 49.8% which was well above the target of 40%. This was the first time the target had been met.
  - The Trust maintained its 100% compliance on complaint responses being issued within 60 working days.

The Committee received reasonable assurance from the report and the discussion.

2. Serious Incident Reporting

The Committee considered and noted the serious incident (SI) reports:

- A total of four serious incidents were declared across April and May 2022, of one which was declared as a Never Event.
- 4 serious incident investigations were concluded.

The Committee heard that the Group Chief Medical Officer was exploring options to align the processes and thresholds for reporting SIs across the Group by facilitating some rotation on the SI panels of the two Trusts. The Committee welcomed this as an opportunity to learn across the Group.

3. Infection Control Update

In 2022/23, as part of its new work plan, the Committee has decided to have a monthly focus on infection prevention and control (IPC), as well as a quarterly IPC update, which supplements the IPC data set out in the Quality Performance Report.

Covid-19 continues to be the major focus of the IPC team. A total of 123 Covid-19 infections were detected in May 2022. Of these, 90 cases were detected within two days of admission; 7 cases between three and seven days of admission; 11 cases between eight and 14 days post admission; and 15 cases detected 15 or more days post admission. A total of 441 Covid-19 positive cases had been detected year-to-date, and there had been a total of 19 deaths of patients who were Covid-positive. There had been three outbreaks on wards in May 2022 which had now been resolved. The trend, however, was that new Covid diagnoses among inpatients had been falling since around mid-April 2022. In line with national guidance, the Trust had updated and relaxed certain aspects of its Covid-19 related IPC arrangements relating to mask wearing in non-clinical areas.

In relation to *C.difficile*, a threshold of 43 cases had been set for the Trust by NHS England for 2022/23 as a whole, which equated to around 3.5 cases a month. In April, there had been 13 cases, 10 of which were classified as Hospital Onset Healthcare Associated (HOHA). In May, there had been 5 cases, all of which were HOHA. This meant that the year had started significantly above trajectory. The Committee was assured that the IPC team were working well with clinical teams to address this.

The Committee heard that, in relation to Monkeypox, the regional Infectious Diseases Unit based at the Trust, together with South West London Pathology, is helping to

coordinate the clinical diagnosis and management of cases in South West London and the Trust was coordinating this work with the national team. A small number of Monkeypox patients had been admitted to the Trust, and local policies for proven and suspected cases of Monkeypox had been developed based on national guidance. Staff responsible for treating suspected Monkeypox cases are assessed by Occupational Health and offered a vaccine in line with national guidance.

4. Maternity Services Report (inc. Clinical Negligence Scheme for Maternity)

The Committee received assurance from the Group Chief Nursing Officer setting out the Trust's position in relation to the actions in the Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme (MIS).

Year Four of the MIS had been launched by NHS Resolution in August 2021 but had been paused due to national staffing shortages in December 2021. The scheme was relaunched in May 2022. The Trust was currently on track to meet all four of the requirements of the MIS.

An assurance visit had taken place on 12 May 2022 to examine the Trust's position in relation to immediate and essential actions arising from the interim Ockenden review. As reported to the Committee in May, the Trust was 100% compliant with these actions and this had been confirmed through the assurance visit. The visit had been very positive and had found there is a strong focus on providing high quality, safe, effective care to all women using the service at St George's, with high levels of psychological safety among staff and a culture of mutual respect and innovation, with services responsive to the needs of the local population. The visit had found that there is outstanding, compassionate leadership across the triumvirate and effective multi-disciplinary team working. The report of the visit, which will be reviewed in detail by the Committee at its meeting in July, had found that both site and group level leadership teams are highly engaged with maternity and are sighted on supporting the leadership team to maintain a safety culture, which included a willingness to take difficult decisions and deal appropriately with any negative workplace behaviours. The Committee was assured by this and extended its thanks and congratulations to the maternity team and to Jan Bradley, Director of Midwifery, in particular, but also emphasised its intention to continue with close monitoring of maternity services to ensure these high standards were maintained.

5. Learning from Deaths Report Q4 2021/22

The Committee reviewed the Quarter 4 2021/22 report on learning from deaths, which is scheduled to be considered by the Board later on the agenda. Given this, I will simply highlight that the Committee was assured that the improvements introduced through the three-part clinical governance improvement programme were being embedded in respect of mortality monitoring, that the Standardised Hospital Mortality Indicator (SHMI) continues to be as expected, and that the Hospital Standardised Mortality Rate (HSMR) is lower than expected.

6. Cardiac Surgery Report

The Committee received its regular quarterly report on cardiac surgery and, based on the quality and safety data presented, was assured regarding the continued safe operation of the service. The Committee was briefed on the Regulation 28 (Prevention of Future Deaths) Notice which had been issued by HM Coroner for Inner West London in May 2022 and noted the Trust's plans for responding to the Notice.

7. Clinical Audit Plan 2022/23

The Committee reviewed the Clinical Audit Plan for 2022/23 which covered both the mandatory audits and those which responded to internal priorities. Carolyn Johnston, Deputy Chief Medical Officer, outlined the steps taken to define a range of smart

outcome measures which had been included in the audits plans which would help to ensure the Trust not only measured quality but also took clear action to move it on and improve it.

While the Committee endorsed the plan and agreed it could be assured that an appropriate arrangements were in place to deliver clinical audit over the year ahead, it also reflected on how, in future, it could take assurance into the issues and concerns raised through the clinical audit programme and requested that the Group Chief Medical Officer give consideration to bringing a report to the Committee on an annual basis analysing the outcomes of audits and highlighting any issues of concern and actions being taken in response.

8. Draft Quality Accounts 2021/22

The Committee reviewed the Trust's draft Quality Account 2021/22 ahead of review by the Audit Committee and the Board. The revised guidance issued at the start of the pandemic meant that there would be no external assurance on the Quality Account this year and so scrutiny by the Quality Committee was particularly important. Following detailed review, the Committee agreed to recommend the report to the Audit Committee.

9. Research Strategy Implementation Report

The Committee received the regular quarterly report on the implementation of the Trust's Research Strategy and was assured that this was progressing well. The Trust had been awarded NIHR Clinical Research Facility designation for the first time and had received funding of £1m from a bid of £3.5 to commence in September 2022. Funding from the Trust had been received to fully invest in staffing to support the implementation. Specialist groups are being set up within the Translation and Clinical Research Institute (TACRI). The Committee welcomed the progress achieved to date and the effective ongoing collaboration with St George's University of London.

10. Board Assurance Framework and Corporate Risk Register

The Committee considered the Board Assurance Framework (BAF) at its meetings in May and June 2022, including the proposed Q1 2022/23 position for reporting to the Board. It agreed that there were no material changes which would warrant a change to the risk scores or assurance ratings for the three strategic risks allocated to it by the Board:

- **Strategic Risk 1 – Patient Safety:** The Committee agreed the risk score of 16 and assurance rating of 'partial' at Q1. It also agreed to the proposal of a year-end target risk score of 12, which was considered to be stretching but attainable.
- **Strategic Risk 2 – Clinical Governance:** Having agreed to reduce the risk score from 12 to 8 and increase the assurance rating to 'good' at its meeting in March 2022 following the completion of the clinical governance improvement programme, the Committee agreed that a continuation of the current risk score and assurance rating at Q1 was appropriate. A year-end target risk score of 8 was agreed, and the Committee noted the challenges in setting a target lower than this given the inherent complexities and risks around clinical governance in an organisation of the size of St George's.
- **Strategic Risk 10 – Research:** The Committee noted that the actions to address the gaps in control and assurance were scheduled for completion in December 2022 and were assured these were on track. It therefore agreed to retain at Q1 the risk score of 9 and assurance rating of 'good'. A target risk score of 6 was agreed for year end.

At its June 2022 meeting, the Committee considered the risks on the Corporate Risk Register, that is those scored 15 and above, which related to quality and safety. The Committee welcomed this opportunity to review the risks that sit below the BAF:

- Risk 2051: Risk of exposure to the Covid-19 virus. Risk score 15 (5c x 3l)
- Risk 2108: Lack of Trust capacity (physical capacity, equipment and workforce) to effectively manage Covid-19. Risk score 16 (4c x 4l)
- Risk 1626: Wrong blood in tube. Risk score 15 (5c x 3l).

The Committee noted that the GCCAO was reviewing risk management arrangements and processes across the Group and recognised the importance of this work, but underscored the importance of this work being appropriately resourced.

11. Deep Dive

At its meeting in May, the Committee considered a discussion paper setting out a potential approach to presenting deep dives to the Committee for the balance of 2022/23 and possible topics for these. The purpose of the deep dives would be for the Committee to explore an issue in-depth particularly where the Committee considered assurance was lacking or required further exploration. The Committee endorsed a framework for the selection of deep dive topics, which it had used in previous years, and agreed that a further criterion relating to material opportunities for group-wide learning be added. A fully developed deep dive programme will be presented to the Committee for review at its meeting in July and we look forward to reviewing this.

Pending the consideration of the full deep dive programme for 2022/23, at its meeting in June the Committee held a deep dive comparing performance and themes in each Trust's Quality Account 2021/22 and the opportunity for group-wide learning. The Committee welcomed the presentation of key quality performance data across the two organisations as an opportunity to consider any key areas of difference and whether one could learn from the other.

12. Recommendation

The Board is asked to note the updates from the May and June 2022 meetings.

Dame Parveen Kumar
Committee Chair
July 2022

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Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	2.2
Report Title:	**Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 4 2021/22 (January – March 2022)**		
Lead Director:	Dr Richard Jennings, Group Chief Medical Officer Dr Luci Etheridge, Site Chief Medical Officer		
Report Author:	Kate Hutt, Head of Mortality Services Maureen Emus Ijomoni, Team Leader Mortality and Morbidity Coordinators Mr Ashar Wadoodi, Lead for Learning from Deaths		
Presented for:	Assurance		
Executive Summary:	The paper provides an overview of the work of the Mortality Monitoring Group (MMG) and Learning from Deaths in Q4 2021/22. Updates against agreed objectives for the first 6 months of the year are outlined, encompassing all workstreams included in the local Learning from Deaths framework. A summary of progress against the Quality and Safety Strategy priority related to the strengthening of Mortality & Morbidity (M&M) meetings across the Trust is included. M&M meetings across the Trust continue to be supported by the M&M coordinators team. Clinical Governance leads have been consulted on a core data set and supporting templates, and on formulating guidance which defines minimum standards for M&Ms. Timescales for completion of this work are provided in section 2.1. A summary of 6 months of the PMRT (perinatal mortality review tool) is included which shows full compliance. Also detailed are actions to improve care that have been identified through the review programme. Established local mortality review processes and associated outcomes are reported, including a summary of the findings of structured judgement reviews over the last quarter. To demonstrate processes in relation to monitoring and investigating mortality outlier alerts and understanding mortality at a granular level, a brief update on the current status of investigations is given. This includes timescales for reporting progress to MMG. National mortality measures are also reported. Our summary hospital level mortality indictor (SHMI) is as expected, and our hospital standardised mortality ratio is lower than expected.		
Recommendation:	The Board is asked to: • note the progress against the objectives for MMG and Learning from Deaths • note and support progress against Quality and Safety Strategy through implementation of the M&M team and development of M&M meetings. • consider the assurance provided that current outlier alerts are being investigated robustly and that there is a granular understanding of our mortality data.		

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Supports			
Trust Strategic Objective:	Care. Reducing avoidable harm.		
CQC Theme:	Safe and Effective (Well Led in implementation of new framework)		
Single Oversight Framework Theme:	Safe		
Implications			
Risk:	Work to clearly define and implement Care group and Trust (Learning from Deaths and governance) processes, and their interconnectivity, is progressing but is not fully mature. Finalising this will ensure governance is effectively managed and opportunities for learning are not missed.		
Legal/Regulatory:	'Learning from Deaths' framework is regulated by CQC and NHS Improvement, and demands trust actions including publication and discussion of data at Board level.		
Resources:			
Previously Considered by:	Quality Committee Patient Safety and Quality Group	**Date**	23 June 2022 18 May 2022
Equality Impact Assessment:	This is in line with the principles of the Accessible Information Standard		

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Learning from Deaths and Mortality Monitoring Group (MMG) Report – Quarter 4 2021/22 (January – March 2022)
Trust Board, 7 July 2022

1.0 PURPOSE

The purpose of this paper is to provide the Patient Safety and Quality Group with an update on the work of the Mortality Monitoring Group (MMG) and progress against the Learning from Deaths agenda. The paper also summarises the activity of the Medical Examiner office.

The report describes sources of assurance that the Trust is scrutinising mortality and identifying areas where further examination is required. In line with the Learning from Deaths framework we are working to ensure that opportunities for learning are identified and where appropriate, action is taken to achieve improvements.

2.0 LEARNING FROM DEATHS

In February the Learning from Deaths lead presented an overview of learning from deaths and mortality monitoring to the Grand Round which was attended by 60 people. The session covered the rationale driving the learning from deaths framework and how this is implemented at St George's, explaining the role of the Mortality Review Team. Also explored was the Trust's approach to strengthening Mortality and Morbidity (M&M) meetings in response to the independent governance reviews of 2019 and 2020. Participants were reminded of the support and facilitation role of the M&M co-ordinators team and were introduced to the draft core dataset and draft guidelines for M&M meetings. The session was well received, and the Learning from Deaths lead was invited to return later in the year to provide an update on progress and learning. There was also discussion regarding the link between the Medical Examiner service and the Learning from Deaths programme, and the opportunities for improvement and learning that collaboration presents.

To remain up-to-date and to explore other approaches to mortality monitoring which may further strengthen our work we have engaged in a number of opportunities to share ideas and experiences with other Trusts. The Learning from Deaths Lead has held discussions with their counterpart at Epsom & St Helier in order to understand their approach and to begin developing consistent processes where possible. This was particularly useful in the revision of our policy. Although Epsom & St Helier were not able to share their policy at the time, discussion and their review of our policy confirmed that there is already a large degree of consistency on which we can build.

In addition, the Head of Mortality Services and the M&M Team Leader have met with colleagues at Great Western and have taken part in an education programme run by NHS England & NHS Improvement 'Better Tomorrow: Learning from deaths, learning for lives'. The programme provides both an opportunity to learn from subject matter experts and to hear about improvement journeys of other organisations. Joining this community of practice will support us in the continued development and strengthening of mortality governance.

2.1 Learning from Deaths objectives Q4 2021/22 to Q1 2022/23

The Trust is committed to continuing to improve processes around mortality monitoring, with the aim of maximising learning and consequently, improvements to patient care. To guide that

development in February 2022 MMG agreed several priorities for the following six months. These cover each of the workstreams incorporated in our local Learning from Deaths framework and are summarised in the table below, alongside the action owner and progress to date.

Mortality investigations to be concluded		
Acute myocardial infarction	The service are conducting a full investigation, which is scheduled for completion by August 2022. An interim report will be presented to MMG in June 2022.	Cardiology Clinical Governance Lead
Intracranial injury	Neurosurgery have been asked to investigate this signal and provide a report in May 2022 which provides assurance that there are clear actions designed to improve outcomes, with defined timescales. This programme of work must link with divisional governance processes, with the Divisional Governance Board receiving updates on progress, which in turn should be reported by the division to Patient Safety and Quality Group (PSQG) until PSQG is satisfied that adequate assurance has been provided.	Neurosurgery Clinical Governance Lead
Major trauma (TARN)	The Clinical Lead for Major Trauma provided an update to MMG in April. The key improvement streams which have been identified (chest wall injury, polytrauma and neurosurgery) were summarised. A full report is being finalised which will detail the significant actions required to improve our service. This will be shared with MMG, and progress will be monitored on a quarterly basis.	Major Trauma Lead
Mortality and Morbidity meetings development		
Continue pilot of M&M template, refine and implement more widely	Feedback from Respiratory Medicine and the Emergency Department is largely positive, and we plan to extend to additional care groups in May 2022. We are also gathering views of those that are currently using an adapted version of the SJR (specifically Clinical Infection Unit). Our intention is to complete the pilot in June, finalise the dataset and supporting documentation and templates. Roll out will begin in July and be complete by September 2022.	Ash Wadoodi & Kate Hutt
Define minimum standards for M&M meetings	A draft has been prepared and shared with Clinical Governance Leads. This will be presented for discussion at MMG in May 2022.	Ash Wadoodi & Kate Hutt
Engage with clinical governance leads to ensure that minimum standards are being met	KPIs and audit will be implemented following agreement of minimum standards. Our first audit of implementation and adherence to KPIs will be conducted by December 2022, following trust-wide implementation by September 2022. A quarterly programme of audit will be in place until MMG is assured that a consistent approach is	Ash Wadoodi & Kate Hutt

	embedded. The frequency of audit will then be reconsidered by MMG.	
Explore ways to collate and share learning, possibly including development of a database and reporting to MMG	Ad hoc sharing of learning takes place and at divisional PSQG in February divisions were reminded to include this in their quarterly reports. Once staffing levels are restored we will move forward with research into databases available and the potential to develop an inhouse system .	Ash Wadoodi & Kate Hutt
Recruit to vacant posts	Complete. The two vacant posts were successfully recruited to in March. We anticipate new team members will take up post in June.	Kate Hutt & Maureen Ijomoni
Participate in TIAA evaluation of current status of service	We have met with the internal auditors and provided all requested information. It is anticipated that the audit will be completed in May.	Ash Wadoodi & Kate Hutt
Learning from Deaths agenda		
Train and induct new reviewers so that we have a full mortality review team	Complete. All reviewers are trained and are completing structured judgement reviews.	Ash Wadoodi
Define standard operating procedures for Learning from Deaths processes	Scheduled for discussion at MMG in June 2022.	Kate Hutt & Ash Wadoodi
Review MMG terms of reference	Complete. These have been updated and agreed at MMG in April.	Kate Hutt
Review Learning from Deaths policy	The policy has been reviewed with only minimal revisions required. MMG endorsed the policy in MMG in March and will be presented to PSQG for ratification in June.	Kate Hutt

2.2 Development of Mortality & Morbidity processes

The Mortality & Morbidity (M&M) coordinators service is now well established. Due to resignations in December 2021, the team currently has two vacant posts; however, the recruitment process is underway with interviews completed at the end of March 2022 to fill the positions. Two new coordinators have been appointed with the expectation that both will be in post by the end of June 2022, subject to the successful completion of recruitment checks.

All clinical teams that require administrative support have an allocated coordinator who is facilitating the meetings and supporting mortality governance. Cover arrangements within the team have also been defined and are working well, ensuring that effective support is maintained in all circumstances. This has been of great benefit during this period of reduced staffing. The coordinators are beginning to support the sharing of learning through enabling liaison between teams where M&M discussion identifies consideration of the case is required within another service. Through linking with the SJR process where additional information is required they are also able to provide additional assurance.

Following presentation of the proposed M&M core data set and supporting templates to the Clinical Governance Leads forum in November a pilot was initiated. This will assist in providing feedback and suggestions for improvement, in addition to assisting in the development of additional guidance and key performance indicators. These will be presented to the Mortality Monitoring Group (MMG) for input, review, and approval prior to implementation across all care groups.

The dataset has been provisionally introduced and is being utilised by the Emergency Department and Chest Medicine care groups. The designated coordinators for each care group have worked with the clinical governance leads to modify the template and incorporate data items and discussion criteria which are specific to the individual care group while maintaining the core data sets central to each case review.

The modified template was formally introduced to the wider emergency medicine team at their clinical governance meeting in February 2022. The feedback remains positive, and the team continue to use the template. In April 2022, the Learning from Deaths Lead, Head of Mortality Services and M&M Team Leader met with the Governance Lead for Chest Medicine to collate feedback on the utilisation of the template. The template has been well received among the chest medicine group with recommendations provided regarding the overall scoring of cases based on 'avoidability' judgement.

The M&M teams plans for the next quarters of 2022 include, but are not limited to, recruiting several other care groups to pilot the proposed template in order to gain more feedback and recommendations, and setting KPIs for the development of the service. The timelines for this work are detailed in section 2.1 of this report. It should also be noted that our internal auditors, TIAA, will be conducting an audit of progress against actions from the governance reviews of 2019 and 2020 which relate to mortality governance.

Strategic priority		1: Improve patient safety by minimising avoidable harm	
Area of focus		We will establish and implement standardised Mortality and Morbidity monitoring processes supported by relevant documentation, performance metrics and processes for shared learning	
Link to corporate objective & strategic risk		Care: Strategic risk 1 [Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation] Corporate objective: Embed a quality, safety and learning culture through monthly patient safety, mortality and morbidity meetings for every specialty	
Executive Lead		Chief Medical Officer	
Operational Lead		Medical Lead for Learning from Deaths	
Implementation stages	Q1	Complete recruitment process for M&M coordinators	Complete
	Q2	Embed M&M coordinators in practice • Map M&M meetings and allocate coordinators • Define core data set & essential elements of meetings • Implement standardised agenda & supporting documentation (pilot) • Highlight and share the learning	 Complete Complete In progress Ongoing
	Q3	Embed M&M coordinators in practice • Revise standardised documentation and embed in practice • Highlight and share the learning	 In progress (pilot)
	Q4	Embed M&M coordinators in practice • Highlight and share the learning	Ongoing

Success measure/target	Maintain SHMI within control limits (value <1) Scheduled M&M meetings in place, supported by M&M coordinator with standardised documentation and feedback via: • Care group leads meetings • Divisional performance reviews • Learning from Deaths report • Patient Safety Bulletin

2.3 Medical Examiner Service

Each quarter all Medical Examiner (ME) offices are required to make a return directly to the office of the National ME, as summarised below. This quarterly return is used for financial reimbursement of costs, and to quantify the level of activity and outcomes of each service. These data are presented to the Regional ME team prior to submission to the National ME and feedback on performance continues to be positive. Below is a summary of the key data submitted by St George's ME office.

A key function of the ME service is to support the appropriate referral of deaths to the coroner. This quarter 101 deaths were referred. In 27 (26.7%) of these cases the coroner felt no further investigation was required and gave the doctor permission to issue the medical certificate of cause of death. This is associated with the coroner issuing a Form 100A, which indicates to the registrar that the coroner is aware of the death and that the death can be registered without any further investigation. In the remaining 74 (73.3%) cases, the coroner felt that further investigation, such as a post-mortem or inquest was required.

The ME service continues to seek opportunities to support learning through identifying potential issues to local clinical governance processes, including referral to the Lead for Learning from Deaths, to the Patient Safety Team or to the clinical team involved with the patient's care. This quarter, such a case was flagged to radiology. The case involved a patient seen in ED after a fall and following discussion at the Radiology Events and Learning Meeting (REALM) a change in practice for first line examination in such clinical scenarios has been defined and agreed.

DEATHS OCCURING AT THE ME OFFICE SITE THAT HAVE BEEN SCRUTINISED BY THE ME	
Number of in-hospital deaths scrutinised	**398**
Adult deaths	
Cases not notified to the Coroner and MCCD issued directly	286
Cases notified to the Coroner and MCCD issued following agreement by Coroner	27
Cases referred to the Coroner and taken for investigation	74
Child deaths	
Cases not notified to the Coroner and MCCD issued directly	8
Cases notified to the Coroner and MCCD issued following agreement by Coroner	0
Cases referred to the Coroner and taken for investigation	2
Timeliness and rejections by registration service	
Number of MCCDs not completed within 3 calendar days (NB: no account of Bank Holidays or weekend and requirement is 5 days)	35
Number of MCCDs rejected by registrar after ME scrutiny	1
Number of cases where urgent release of body is requested and achieved within requested time	25

Number of cases where urgent release of body is requested and NOT achieved within requested time		2
Achieving communication with the bereaved		
Number of deaths in which communication did not take place		23
Reasons for no communication:	Declined	0
	No response	13
	No NOK	7
	Not documented	3
Detection of issues and actions		
ME referred for structured judgement review		37
ME referred to other clinical governance processes		2
ME referred to external organisation		0
Families referred to PALS		4

Our new team of three Medical Examiner Officers (MEO) took up post this quarter and are working hard to support the Medical Examiners in all areas of delegated responsibility. MEOs support MEs in their role scrutinising the circumstances and causes of death. They are a point of contact and source of expert advice for the bereaved, healthcare professionals and coroner and registration services. Our MEO team are also supporting improvements, such as communicating compliments received from families to clinical teams and informing clinical teams when the coroner issues a Form 100A.

With a full team in place, we have been 'on-boarded' to the digital ME case management system which is in testing phase. This is alongside our ongoing support of testing and research on the digital platform.

Our work to extend scrutiny to the non-acute sector is ongoing. The Lead ME and Head of Mortality Services have continued to meet with our Merton and Wandsworth GP task and finish group and have identified two pilot sites in Merton. We have had a number of planning meetings with those teams and anticipate starting our first pilots in May. Our funding for MEs has been extended from 1.1 to 1.2 WTE and we are currently working through the recruitment process, targeted in particular at GP colleagues.

2.4 Perinatal Mortality Review Tool (PMRT)

The Clinical Negligence Scheme for Trusts (CNST) Maternity Incentive Scheme is being run by NHS Resolution for a fourth year. The scheme requires Trusts to demonstrate compliance with ten key safety actions in order to receive a rebate on the yearly CNST premium.

Safety Action One measures compliance with the use of the National Perinatal Mortality Review Tool (PMRT). This tool supports systematic, multidisciplinary high-quality reviews of the circumstances and care leading up to and surrounding each stillbirth and neonatal death, and the deaths of babies who die in the post-neonatal period having received neonatal care. The reviews are used to understand, wherever possible, why the baby died and whether different actions would have led to a different outcome. Active communication with parents is central to this process. Parents are invited to contribute to the review and receive a plain English copy of the investigation once completed.

The service provides a quarterly report to demonstrate that quality and safety are being reviewed and that learning is identified and drives change. The comprehensive report is considered at divisional governance meetings and is subsequently presented to MMG. A summary is included in this quarterly report to provide assurance to Patient Safety and Quality Group, Trust Management Group, Quality and Safety Committee and ultimately the

Trust Board. Trust Boards are asked to sign a declaration to confirm the level of compliance against each standard.

This summary relates to all eligible perinatal deaths in the period 21st March 2021 to 20th June 2021 and 21st June 2021 to 21st September 2021 and the actions and learning arising from them.

Standards from CNST Safety Action One	**Compliance**	
	21st March 2021 to 20th June 2021	21st June 2021 to 21st September 2021
1. i) All perinatal deaths eligible to be notified to MBRRACE_UK from 01/09/21 must be notified within 7 working days and required surveillance information must be completed within 1 month. **1.** ii) A review using PMRT of 95% of eligible deaths from 08/09/21 will have been started within 2 months of each death.	We are **compliant** with this standard. Achieved 100% We are **compliant** with this standard. Achieved 100%	We are **compliant** with this standard. Achieved 100% We are **compliant** with this standard. Achieved 100%
2. At least 50% of eligible deaths of babies who were born and died at the Trust, including home births, from 08/09/2021 will have been reviewed using the PMRT, by a multidisciplinary review team. Each review will have been completed to the point that at least a PMRT draft report has been generated within 4 months and report published within 6 months.	We are **compliant** with this standard. Achieved 100%	We are **compliant** with this standard. (Achieved 64% of cases in draft and 71% published)
3. For 95% of all deaths of babies who were born and died in the Trust from 08/09/2021, the parents will have been told that a review will take place, and that the parents' perspectives and any concerns have been sought. This includes any home births where care was provided by Trust staff.	We are **compliant** with this standard. Achieved 100%	We are **compliant** with this standard. Achieved 100%
4. Quarterly reports will have been submitted to Trust Board from 08/09/2021. These reports should be discussed with the Trust maternity safety and Board level safety champions.	We are **compliant** with this standard.	We are **compliant** with this standard.

In the first period (March to June 21) two of the completed reviews were graded as having issues which would not have made a difference to the outcome. There were two cases in which the panel identified issues that may have affected the outcome for the baby. The themes that arose were maternal observations not completed in labour, fetal surveillance not performed correctly, lack of involvement of senior clinicians in care management plans, and inability of staff to review patients appropriately due to reduced triage capacity.

There were two cases that met the referral criteria for the Healthcare Investigations Safety Branch (HSIB) [references MI-003719; MI-003729]. An immediate support and learning plan was put in place for the staff members involved in one case and there has been an urgent

review of the delivery suite triage capacity and systems for the other. An immediate action learning plan was completed on 1st December 2021.

The reports for these cases have now been received by the trust and actions have been devised and are being implemented. A review of the day assessment unit and management of hypertension guidelines are underway. In the short term there has been a review of triage capacity and steps have been taken to ensure another triage room is available moving forward. A longer-term review of triage is also ongoing, and plans are in place to implement a traffic light triage system. The Quality Improvement (QI) lead has completed a notes audit of triage assessment and since these cases a band 7 midwife has been recruited to support junior midwives and ensure competency in developing midwifery skills.

In the second period (June to September 21) there were two cases where the review group identified issues that were felt not to have impacted on the outcome for the baby. There were five cases where issues were identified which may have affected the outcome for the baby. Themes that arose from these reviews, alongside improvement actions taken in response are summarised below.

Need for a clear pathway for women who present un-booked in pregnancy.	The pathway has been revised and communicated to all staff via the maternity unit communication bulletin. . It has been added to the multiple pregnancy guideline and further clarified in the antenatal guideline. This was undertaken through the established audit and guideline group process. The case has also been presented at the multi-disciplinary team case discussion meeting. Individual feedback has also been given to the medical and midwifery staff involved.
Need for immediate CTG monitoring should patient's report a change in symptoms following prolonged rupture of membranes	It has been communicated to all midwives that severe intra-uterine sepsis may not be obvious in maternal observations, and that other signs such as a change in discharge may be clinically significant. Staff have been informed that there should be a low tolerance for commencing a CTG in cases of prolonged preterm rupture of membranes and threatened preterm labour. This case has also been reviewed at the Governance multi-disciplinary team meeting.
Inadequate metabolic, thermal and glycaemia management at booking Trust prior to and during transfer to St George's.	Management of the baby prior to and during transfer has been fed back to the booking Trust, who attended the multi-disciplinary team meeting to discuss this case, and to the Neonatal transfer team.

One of the cases noted above was a stillbirth case which was declared and investigated as a serious incident [ref STEIS 2021/18848]. The findings, including the root cause and conclusion, and actions were reported in the Serious Incidents report to PSQG and QSC in February 2022.

The report notes that common amongst PMRT meetings, both locally and nationally, that it is very difficult to get external representation on panels. This challenge has been compounded by staff shortages during the pandemic. This will be discussed at the next department Risk and Governance business meeting and possible solutions sought.

3.0 MONTHLY INDEPENDENT REVIEW OF MORTALITY

This quarter we welcomed the second of our new consultant mortality reviewers to the Mortality Review Team (MRT). This increased resource and the expertise they bring to the team, is having a positive impact on the quantity, quality, and timeliness of reviews. It has also allowed for more robust follow-up and escalation, where required, as each reviewer has more capacity to take this important part of the role forward. Next we will consider how we can further strengthen the Mortality Review Team by making it multi-professional.

During this quarter, independent reviews, using the structured judgement review (SJR), have been completed for 43 deaths. 37 of these were referred to the Learning from Deaths Lead by the Medical Examiner Office. The reasons for requesting a review are summarised below.

Triggers for review	
Confirmed learning disability	7
Significant mental health diagnosis	9
ME or clinical team detected possible learning or potential issue with care	13
Deaths following elective admission	4
Areas subject to enhanced oversight	7
Deaths where possibility of hospital acquired covid-19 infection	3

The findings from these structured judgement reviews are shown below. It should be noted that the SJR is completed by a consultant who is independent of the care of the patient and is a first stage review process, conducted through a casenote review. Where the reviewer has questions or concerns these are raised with the clinical team and/or the Patient Safety Team and therefore the judgements reached at the initial review, and documented here, may not constitute final conclusions about treatment and care.

SJRs may be used as one element of a full portfolio of information considered in the evaluation of patient safety incidents at the weekly Serious Incident Declaration Meeting (SIDM). During this quarter there have been seven serious incidents (SIs) where the patients involved had died at the point of SI declaration.

These cases are reported to Quality and Safety Committee (QSC) monthly, both at the point of declaration and again once the investigation is complete. Through this mechanism QSC are informed of immediate risk mitigation actions and the findings of completed investigations, including the root cause, conclusion, and improvement actions.

3.2 Overview of January 2022 to March 2022

Between January and March 2022 there were 398 deaths. Members of the Mortality Review Team (MRT) reviewed 43 deaths, representing 10.8% of deaths. The findings from these structured judgement reviews are summarised below. It should be noted that all child deaths are reviewed locally by clinical teams and by the Child Death Overview Panel.

The structured judgement review methodology requires reviewers to identify problems in healthcare and to assess whether these have caused harm. Of the 43 deaths reviewed this quarter problems were identified in relation to 14 (32.5%) of the patients reviewed. Two patients experienced two problems in healthcare, resulting in 16 problems in total.

Problem in healthcare	No harm	Possible harm	Harm	TOTAL
Assessment	0	0	1	1
Medication	0	0	0	0
Treatment	1	2	0	3
Infection control	1	3	0	4
Procedure	0	0	0	0
Monitoring	1	4	0	5
Resuscitation	0	0	0	0
Communication	1	1	1	3
Other	0	0	0	0
TOTAL	4	10	2	16

An assessment of overall care is also provided for each death reviewed. In 8 deaths (18.6%) the care provided was rated as excellent. For most patients (25, 58.1%) care was evaluated as good; for 9 patients (20.9%) care was felt to have been adequate. In one case, where a possible failure to monitor the patient was observed, care was rated as poor. The SJR was shared with the Patient Safety Team and formed part of the discussion at SIDM, which resulted in the division being asked to complete and adverse incident (AI) investigation (ref DW164102). This investigation is currently underway.

Overall care judgement	Number	Percentage
Excellent care	8	18.6%
Good care	25	58.1%
Adequate care	9	20.9%
Poor care	1	2.3%
Very poor care	0	
Total	**43**	

A judgement regarding avoidability of death is made for all reviews. A breakdown is shown below which demonstrates that in the majority of deaths there was not felt to be any avoidability. No deaths were found to be definitely, or probably, avoidable.

Avoidability of death judgement	Number	Percentage
Definitely not avoidable	35	81.4%
Slight evidence of avoidability	6	14.0%
Possibly avoidable but not very likely (less than 50:50)	2	4.7%
Probably avoidable (more than 50:50)	0	
Strong evidence of avoidability	0	
Definitely avoidable	0	
Total	**43**	

3.3 Learning disabilities

All deaths that occur in patients with learning disabilities (aged 4 and over), and adults with a clinical diagnosis of autism, are reported to the national Learning Disabilities Mortality Review Programme (LeDeR). The LeDeR reviews are co-ordinated by the Clinical Commissioning Group and we have established effective liaison with these colleagues. We work closely

together to share our local independent mortality reviews and in turn receive redacted copies of the completed LeDeR review.

The mortality review team carry out local review of every death which meets the criteria for a LeDeR review using our standard SJR methodology. The table below summarises these deaths from the beginning of 2018/19 to the end of Q4 2021/22. In total there have been 68 deaths, with reviews completed for each. This quarter there have been seven deaths in patients with a learning disability, including one paediatric patient. In each of the cases the death was judged to be definitely not avoidable. Overall care was judged to be excellent for 3 of the patients, and good or adequate for the remaining 4 patients. None of the deaths were felt to be avoidable.

LD DEATHS Avoidability of death judgement score	**2018/19**	**2019/20**	**2020/21**	**2021/22**			
				Q1	**Q2**	**Q3**	**Q4**
TOTAL DEATHS	**9**	**16**	**22**	**4**	**4**	**6**	**7**
REVIEWS COMPLETED	**9**	**16**	**22**	**4**	**4**	**6**	**7**
Definitely not avoidable	9	16	22	2	4	5	7
Slight evidence of avoidability	0	0	0	2	0	1	0
Possibly avoidable (< 50:50)	0	0	0	0	0	0	0
Probably avoidable (> 50:50)	0	0	0	0	0	0	0
Strong evidence of avoidability	0	0	0	0	0	0	0
Definitely avoidable	0	0	0	0	0	0	0

4.0 LEARNING FROM MORTALITY

As detailed in section 2.1 of this report there are three investigations that are ongoing: acute myocardial infarction; intracranial injury and major trauma (TARN). These investigations are in progress and have previously been fully reported, therefore the summaries below provide only a brief update. Each of these investigations must link with divisional governance processes. Divisional Governance Boards should receive updates on progress, which in turn should be reported by the division to Patient Safety and Quality Group (PSQG) until PSQG is satisfied that adequate assurance has been provided.

4.1 Acute Myocardial Infarction

In February 2022 the Clinical Governance Lead for Cardiology attended MMG to provide an update on the ongoing investigation, based on the period April 2021 to December 2021. Review of the mortality cases showed that approximately 90% are patients who present to the hospital with ST elevation myocardial infarction, of which over 75% also present with cardiogenic shock. Three factors that may be require improvement were suggested: the cardiogenic shock pathway, angiogram waiting times, and data quality. These are being taken forward in the ongoing programme of work. It was also noted that several positive steps have already been taken including the opening of two new catheterisation (Cath) labs, the extension of working hours and recruitment of more staff.

The mortality monitory group (MMG) agreed a timeframe of 6 months for service to complete investigations to understand observed signals, as well as promote education and change. An interim update will be provided in June 2022, with the final report anticipated in quarter 2 of 2022/23.

4.2 **Intracranial injury**

In March a consultant neurosurgeon attended MMG to discuss and agree a plan to take forward the understanding and resolution of this ongoing signal. Previously an independent clinical review of cases conducted by the Mortality Review Team, a coding review, a benchmarking exercise, and a specialist review by the neurosurgery team have all been completed and have not identified a cause for the signal nor any areas of concern.

The group were informed of a number of actions underway or planned, including coding validation, a review of the head injury pathway, changes to the NCEPOD theatre list, and the recruitment of consultants with an interest in trauma. These initiatives were welcomed by the group; however, it was agreed that a more robust approach is required. MMG have asked that a neurosurgery group be created to investigate the signal and design any necessary improvements. A clear change plan is required which should define timescales and the anticipated benefits of actions proposed. This will be presented to MMG in May.

4.3 **Trauma Audit & Research Network (TARN)**

Previous versions of this report have explained in detail the nature of the alert and detailed the steps taken in a comprehensive investigation of our outcomes. The Lead for Major Trauma attended the MMG meeting in April 2022 to provide an update on the current position of improvement work. It was noted that a peer review of major trauma was scheduled for 29th April.

The need to change practice, improve culture, and invest resources in the major trauma service were all noted as being integral to achieving improvements in outcomes. Specific clinical workstreams have been identified including management of chest wall injury, polytrauma and neurosurgery. Detailed actions have been proposed in order to address these areas and a comprehensive report is currently being finalised which will provide full details. This will be shared with MMG and reported in the Q1 2022/23 version of this report. Once the action plan is agreed progress will be monitored by MMG on a quarterly basis.

5.0 LATEST NATIONAL PUBLISHED RISK-ADJUSTED MORTALITY

5.1 **Summary Hospital-level Mortality Indicator (SHMI)** [source: NHS Digital]

The latest SHMI data, covering discharges from December 2020 to November 2021, was published on 14th April 2022. The Trust's overall mortality is categorised as 'as expected' at 0.90. We were one of 98 trusts in this category.

During the 12-month period there were 64,635 inpatient spells at the Trust, with 1,535 deaths observed, compared to 1,705 expected deaths. It should be noted that NHS Digital are excluding Covid-19 activity from the SHMI publication in order to make the indicator values as consistent as possible with those from previous reporting periods. The SHMI is not currently designed for pandemic activity and the statistical modelling used to calculate the SHMI may not be as robust if such activity was included. Excluding Covid-19 activity means that, as far

as possible, consistency is maintained and each SHMI publication can be interpreted in the same way.

NHS Digital provides a SHMI value for ten diagnosis groups, detailed below. The latest information is summarised in the table below and shows that our mortality is either lower than, or in line with what would be expected for all the diagnosis groups analysed, other than acute myocardial infarction where mortality is higher than expected. This has been shared with the cardiology clinical governance lead and discussed by MMG. A report on progress against the action plan arising from the mortality investigation previously detailed in this paper (Q4 2020/21) will be presented to MMG in six months' time, alongside an analysis of clinical coding and data.

Diagnosis Group	SHMI value	SHMI banding
Acute bronchitis	*	*
Acute myocardial infarction	1.33	Higher than expected
Cancer of bronchus; lung	0.65	Lower than expected
Fluid and electrolyte disorders	0.82	As expected
Fracture of neck of femur (hip)	1.02	As expected
Gastrointestinal haemorrhage	1.22	As expected
Pneumonia (excluding TB/STD)	0.77	Lower than expected
Secondary malignancies	0.90	As expected
Septicaemia (except in labour), shock	0.96	As expected
Urinary tract infections	0.99	As expected

* Numbers are too low to disclose

5.2 **Hospital Standardised Mortality Ratio (HSMR)** [source: Telstra/Dr Foster]

For the most recent 12 months of data reported by Dr Foster (February 2021 to January 2022) our mortality is lower than expected. In contrast to NHS Digital, Dr Foster Intelligence has not excluded Covid-19 activity from their analysis.

HSMR analysis: February 2021 – January 2022	Value	Banding
HSMR (all admission methods)	84.0	Lower than expected
HSMR: Weekday emergency admissions	79.8	Lower than expected
HSMR: Weekend emergency admissions	94.0	As expected

Analysis of mortality at diagnosis and procedure group level is considered by MMG and the summary below details the areas that the group concluded require further investigation.

Group	Action
Genitourinary symptoms & ill-defined conditions	This signal was first observed in the February 2022 data refresh, when there were 5 deaths observed (out of 584 patients), against an expected 0.8. In the April 2022 data refresh there are 4 deaths observed (out of 597 patients), against an expected 0.7. As an initial step the coding of these cases will be reviewed as this is a very unusual signal.
CABG (other)	This signal was observed in March MMG. There were 10 deaths against 3.5 expected (232 cases in total) over the period December 2020 to November 2021.

	These 10 cases have been considered by the Learning from Deaths Lead. 9 had been subject to an SJR following the death and no avoidability was identified. Furthermore, each death had been discussed at SIDM – none were declared and in only 1 case an AI investigation was completed. Following this review the Associate Medical Director (Cardiac Surgery) was asked for his understanding of the signal. He noted that it is a very heterogeneous group of patients. Only three were CABG operations; the others had primarily valvular problems and two were emergency VSD (ventricular septal defect) closures. Only 3 were elective and the cases were treated by 5 different surgeons. Further it was noted that these deaths had been extensively discussed at M&M meetings, at SIDM, at the Quality and Safety Committee and at the NHS I&E Single Item Quality Group meeting which also provides oversight to the Cardiac Surgery service. No common patterns were detected. This information was considered at MMG in April and the group felt assured that there were no issues that required further investigation. It was noted that the grouping will continue to be monitored and that all cardiac surgery deaths remain subject to enhanced oversight.

It should be noted that no external mortality outlier alerts have been received in this period.

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Appendix 1: Mortality & Morbidity meetings summary

Division: Children and Women, Diagnostics, Therapeutics and Critical Care			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Gynaecology	Fully established	Monthly	
Acute Paediatrics	Fully established	Bi-Monthly (2 months)	Quarterly joint meetings with Paeds ED and PICU + joint meeting with Neonatal Unit 2 times a year
Specialist Paediatrics	Integrated within Acute Paediatrics	Integrated within Acute Paediatrics	Low volume of cases therefore discussed through the Acute Paediatrics M&M
PICU	Fully established	Monthly	
Paediatric Surgery	Fully established	Quarterly	The Clinical Governance lead for paediatric surgery also supports an additional M&M meeting for 'Paediatric Anaesthesia' which takes place 2 times a year.
Diagnostic Radiology	Fully established	6 times a year	
Interventional Radiology	Fully established	Monthly	
Cardiac ICU	Fully established	Weekly	
General ICU	Fully established	Weekly	
Neuro ICU	Fully established	Weekly	
CWDTCC Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Breast Screening and Clinical Genetics. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future. The Obstetric and Neonatal care groups have multiple meetings throughout the month. The M&M team are currently working with the governance leads for each care group to clearly define which meetings the M&M team can provide administrative support to.			

Division: Medicine and Cardiovascular Services			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Emergency Medicine	Fully established	Monthly	Adopted core dataset
Acute Medicine	Fully established	Monthly	
Senior Health	Fully established	Bi-Monthly (2 Months)	
Cardiology	Fully established	Monthly	Meetings alternate between Morbidity and Mortality cases each month to accommodate the volume of cases and facilitate adequate discussion time.
Cardiac Surgery	Fully established	Monthly	
Thoracic Surgery	Fully established	Monthly	
Vascular Surgery	Fully established	Monthly	
Haematology	Fully established	Bi-Monthly (2 Months)	

Oncology & Palliative	Fully established	Monthly (2 times a month)	
Renal	Fully established	Monthly	Renal Transplantation (quarterly) & Vascular Access (4 times a year) are additional M&M meetings under the Renal care group.
Chest Medicine	Fully established	Bi-Monthly (2 Months)	Adopted core dataset
Clinical Infection Unit	Fully established	Monthly	
Dermatology & Lymphoedema	N/A	N/A	Nil M&M activity
Diabetes & Endocrinology	Fully established	Monthly	Low/ Minimal M&M activity. Due to low activity the frequency of the M&M meetings is currently being reviewed, with the possibility of a change to quarterly meetings to facilitate structured case discussions.
Gastroenterology & Endoscopy	Fully established	Monthly & Quarterly	Gastroenterology (Monthly) & Endoscopy(Quarterly) run separate M&M meetings.
Rheumatology	Fully established	Ad-hoc	Low/ Minimal M&M activity. There has been one meeting in 2021 on 29/09/2021.
Medicine & Cardiovascular Services Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Dermatology & Lymphoedema. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future.			

Division: Surgery, Theatres, Neurosciences & Cancer			
Care Group	**Status**	**Frequency of Meetings**	**Additional Information**
Anaesthetics	In progress	In progress	The M&M activity within anaesthetics is being reviewed and there are on-going plans to commence routine M&M meetings; the designated coordinator assigned to anaesthetics has reached out to the governance lead to facilitate the provision of administrative support.
Neurology	Fully established	Quarterly	
Interventional Neuroradiology	Fully established	Monthly	
Neurosurgery	Fully established	Bi-Monthly (2 Months)	
Stroke	Fully established	Monthly	

Trauma & Orthopaedics	Fully established	Bi-Monthly (2 Months)	
ENT & Audiology	Fully established	Quarterly	
General Surgery	Fully established	Monthly	
Maxillofacial	Fully established	Monthly	
Plastic Surgery	Partially established	Ad-Hoc	Low/ Minimal M&M activity
Urology	Fully established	Monthly (2 times a month)	
Cancer	Integrated within other care groups	-	
STNC Notes: The following care groups do not have meetings due to no/minimal mortality & morbidity activity – Neurorehab, Pain Clinic, Dentistry, and SWL Pathology. The Team Leader has met with all Clinical Governance Leads for these care groups and informed them of the M&M team service should a need for administrative support with M&M meetings arise in the future.			

Appendix 2: National Quality Board Dashboard – data to 31st March 2022

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - March 2021-22

Description:
The suggested dashboard is a tool to aid the systematic recording of deaths and learning from care provided by NHS Trusts. Trusts are encouraged to use this to record relevant incidents of mortality, number of deaths reviewed and cases from which lessons can be learnt to improve care.

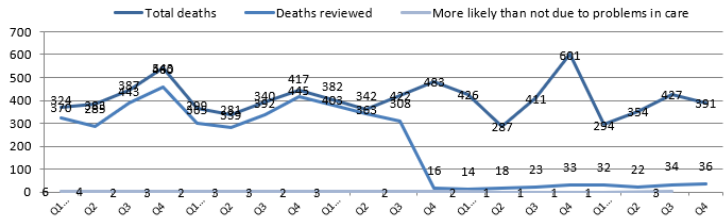
Summary of total number of deaths and total number of cases reviewed under the Structured Judgement Review Methodology

Total Number of Deaths, Deaths Reviewed and Deaths deemed more likely than not due to problems in care (does not include patients with identified learning disabilities)

Total Number of Deaths in Scope		Total Deaths Reviewed		Total Number of deaths considered more likely than not due to problems in care PRISM Score<=3 or equivalent measure	
This Month	Last Month	This Month	Last Month	This Month	Last Month
120	130	11	13	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
391	427	36	34	0	3
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
1466	1725	124	88	4	5

Time Series: Start date 2017-18 Q1 — End date 2021-22 Q4

Mortality over time, total deaths reviewed and deaths considered more likely than not due to problems in care
(Note: Changes in recording or review practice may make comparison over time invalid)



Total Deaths Reviewed, categorised by SJR Avoidability Score

Score 1 Definitely avoidable			Score 2 Strong evidence of avoidability			Score 3 Probably avoidable (more than 50:50)			Score 4 Probably avoidable but not very likely			Score 5 Slight evidence of avoidability			Score 6 Definitely not avoidable		
This Month	0	0.0%	This Month	0	0.0%	This Month	0	0.0%	This Month	1	9.1%	This Month	0	0.0%	This Month	10	90.9%
This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	0	0.0%	This Quarter (QTD)	2	5.6%	This Quarter (QTD)	6	16.7%	This Quarter (QTD	28	77.8%
This Year (YTD)	0	0.0%	This Year (YTD)	0	0.0%	This Year (YTD)	4	3.2%	This Year (YTD)	6	4.8%	This Year (YTD)	18	14.5%	This Year (YTD)	96	77.4%

St George's University Hospitals NHS Foundation Trust: Learning from Deaths Dashboard - March 2021-22

Summary of total number of learning disability deaths and total number reviewed under the LeDeR methodology. Please note that all LD deaths are reviewed using our standard approach, pending reviews as directed by the LeDeR process. The outcome of these local reviews is displayed in the second data grouping below.

Total Number of Deaths, Deaths Reviewed and Deaths Deemed more likely than not due to problems in care for patients with identified learning disabilities

Total Number of Deaths in scope		Total Deaths Reviewed Through the LeDeR Methodology (or equivalent)		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
3	2				
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
7	6				
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
21	22				

Total Number of Deaths in scope		Total Deaths Reviewed Through the Local Review Methodology		Total Number of deaths considered more likely than not due to problems in care	
This Month	Last Month	This Month	Last Month	This Month	Last Month
1	2	1	2	0	0
This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter	This Quarter (QTD)	Last Quarter
4	4	4	4	0	0
This Year (YTD)	Last Year	This Year (YTD)	Last Year	This Year (YTD)	Last Year
8	22	8	22	0	0

Time Series: Start date 2017-18 Q1 — End date 2021-22 Q4

Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**2.3**
Report Title:	Integrated Quality & Performance Report		
Lead Director/ Manager:	James Marsh, Group Deputy Chief Executive Officer		
Report Author:	Kaye Glover, Emma Hedges		
Presented for:	Assurance		
Executive Summary:	This report consolidates the latest management information and improvement actions across our productivity, performance, and workforce for the month of May 2022. **Our Finance & Productivity** Outpatient performance is expected to be at 110% of May 2019 levels which is higher than the 96% plan submitted. First attendance activity levels in the month were in line with pre-covid levels. Elective and Daycase performance is expected to be slightly behind trajectory (after estimated catch up), with a percentage of 95%, lower than the 96% plan submitted for May. Positive increase in activity was seen supported by significant improvements in theatre utilisation rates. The first Theatres Transformation Board took place on Tuesday 14th June with priorities identified. **Our Patient Perspective** In May performance against all Life Support training was non-compliant. For Immediate Life Support (ILS) training the rate was 70.4%; Basic Life Support rate (BLS) it was 81.6% and Advance Life Support (ALS) was 82.1%. Ongoing review of the Training Needs of all Trust staff will be completed by the end of June. There were 15 Hospital Onset Health Associated (HOHA) COVID-19 infections and 11 Hospital Onset Probably Associated (HOPA) COVID-19 infections. The trajectory for 2022-23 is no more than 43 cases compared to 52 for 2021-22. There were 2 cases of P. aeruginosa bacteraemia during May 2022 and 5 cases of Klebsiella spp. In Maternity Services, the month of May saw an increased birth rate with obstetric and medical complexity remaining high. Staffing remained challenging across the month with sickness and covid isolation, along with lead in times for recruitment start dates. Despite ongoing challenges, the Labour Ward coordinator remained supernumerary for 100% of the time and excellent performance continues in antenatal bookings with 98.25% of women referred being booked by 12 weeks and 6 days. Operational pressures in ED and increased waiting times continue to impact our ED FFT performance. Inpatient, Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good ". **Our Process Perspective** Performance against the Four-Hour Operating Standard remains challenged with performance at 73.9% for May. Front end capacity remains constrained with an		

	increasing number of patients waiting in ED for over 12 hours following a decision to admit, driven by increased attendance, high acuity and rising occupancy rates. The Trust continues to work seamlessly with system partners to reduce the number of medically fit patients ready for discharge to allow better bed allocation and a number of projects are in place to help support capacity and flow. Cancer performance against the 14-day standard in April was 79.8% against a target of 93%. Increase in performance driven by an improved position within Breast Services. The 62-day performance was at 71.7%, ahead of the agreed trajectory of 70%. The backlog trajectory is being met and the Trust has agreed to improve performance by March 23 to 80% with the alliance. FDS performance continues to achieve target. The Cancer improvement Programme 2023/24 overseen by the trust cancer group will focus on several priorities to help improve and support cancer waiting times for our patients. At the end of May, the Trust reported that 1.5% of patients were waiting for more than six weeks to have a diagnostic test, an improvement of 0.9% compared to April. Improvement seen within Cardiac MRI, Sleep Studies and Cystoscopy. Cardiac MRI continues to hold the majority of breaches with continued capacity pressures, improvement in month was driven by additional admin support enabling the service to proactively manage attendances, however, additional capacity not expected until September 2022. At the end of April, 911 patients waiting longer than 52 weeks, an additional 65 patients compared to March and above trajectory of 880. April was a challenging month for activity with the reduction in working days impacting on the number of clock stops and removals. In addition, the average number of clock stops per working day was not sufficient to offset a continued increase in the average daily number of referrals. Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London. **Our Workforce Perspective** HR continues to work with managers to support our staff on long- and short-term sickness. This includes, making timely Occupation Health referrals to establish support for staff such as due consideration for reasonable adjustments and developing a toolkit to support staff who are returning after sickness absence. A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals. A review of the complete recruitment process and dovetailing this with retention plans is being undertaken.
Recommendation:	The Board is requested to note the report
Supports	
Trust Strategic Objective:	Treat the Patient Treat the Person Right Care Right Place Right Time
CQC Theme:	Safe, Caring, Responsive, Effective, Well Led
Single Oversight Framework Theme:	

Implications			
Risk:	NHS Constitutional Access Standards are not being consistently delivered and risk remains that planned improvement actions fail to have sustained impact		
Legal/Regulatory:			
Resources:	Clinical and operational resources are actively prioritised to maximise quality and performance		
Equality and Diversity:			
Previously Considered by:	Quality Committee Finance & Investment Committee	**Date**	23/6/2022 24/6/2022
Appendices:			

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Integrated Quality and Performance Report

For Trust Board
Meeting Date – 7 July 2022

James Marsh - Group Deputy Chief Executive Officer

16 June 2022

Our Outcomes

How Are We Doing?

June 2022

Daycase and Elective Surgery operations

Actual: 4,868

2019/20 Actual 5,561

6 Week Diagnostic Performance

Actual: 1.5% Target: 1%

Four Hour Emergency Standard

Actual: 73.9%

Plan: 95%

Whole Trust Inpatient Friends and Family Test

Actual 98.9%

Target 95%

Outpatient First Attendance

Actual 19,143

2019/20 Actual: 18,489

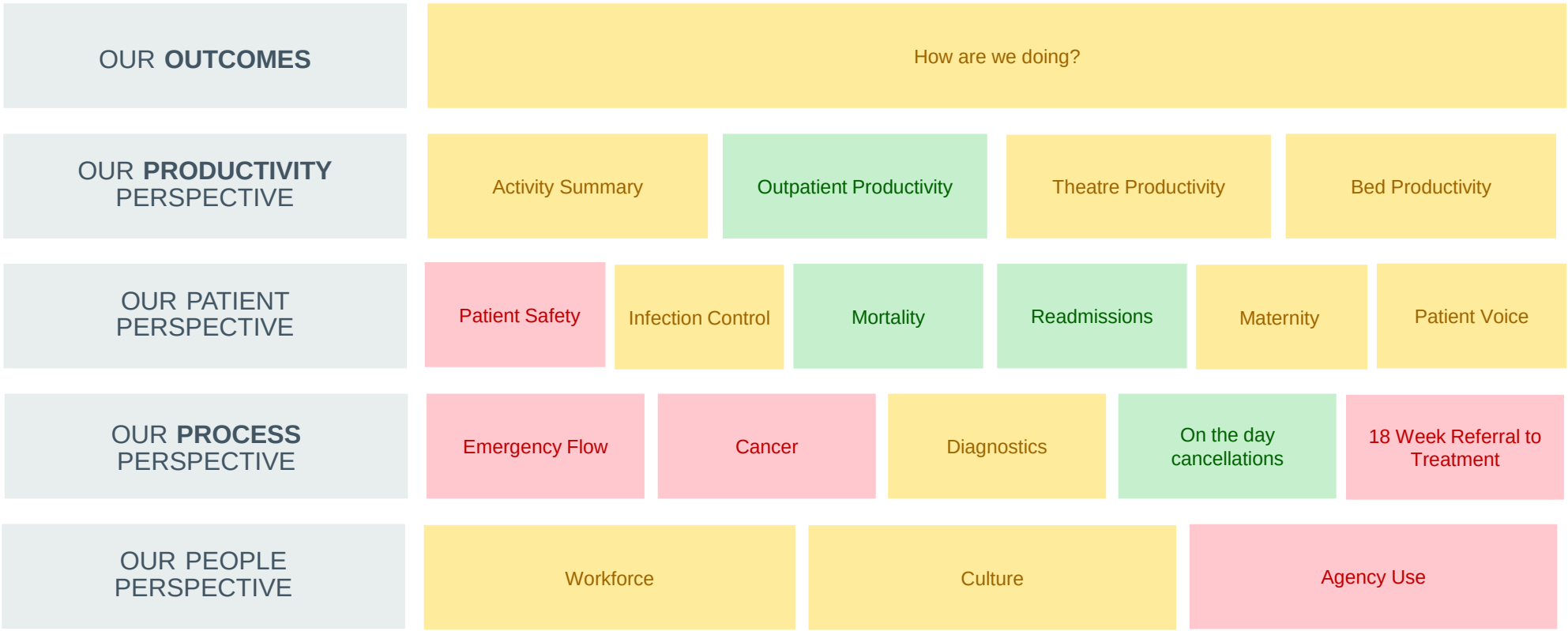
May 2022

Referral to Treatment Standard - Number of 52 Week Breaches

911

Outstanding care every time

Balanced Scorecard Approach



Executive Summary – May 2022 (1 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Finance & Productivity Perspective	• All outpatient activity in May 2022 is expected to be at 110% once data catch up is complete, which is higher than the 96% plan. First outpatient increased significantly to pre-covid levels. • Elective and Daycase performance is expected to be behind plan (after estimated catch up), with a percentage of 95%, slightly below the 96% trajectory submitted for May. Theatre utilsation rates have seen a positive increase exceeding the upper control limit. • Non-Elective Lengths of Stay (LOS) remains high, driven by increased acuity, medically fit patients awaiting discharge and high occupancy rates. This is mainly impacting Senior Health and Acute Medicine	Outpatients • Working with services to revise clinic templates to free up space for face to face activity and will continue to work with Estates to create a Virtual Clinic Hub • Additional clinics to address the large number of patients referred via the Two Week Rule pathway are being undertaken • The launch of the Patient Portal Daycase & Elective activity • 16 Anaesthetic consultants and Specialty Doctors have been successfully recruited. 10 more posts are currently (or imminently) out to advert • The first Theatres Transformation Board took place on Tuesday 14th June with priorities identified Length of Stay • Work to optimise Discharge to Assess process with Merton and Wandsworth • Review of the stranded patient weekly call Terms of Reference and functionality • The Departure Lounge improvement project is underway with a view to increase the capacity and utilisation of the lounge • Focus on improving the number of weekend discharges
Patient Perspective	• In May performance against all Life Support training was non-compliant. For Immediate Life Support (ILS) training the rate was 70.4%; Basic Life Support rate (BLS) was 81.6% and Advance Life Support (ALS) was 82.1%, all against a target of 85% • Category 3, 4 and Unstageable Pressure Ulcers per 1,000 bed days shows special cause deterioration at 0.60 per 1,000 bed days compared to the mean of 0.30. • There were 15 Hospital Onset Health Associated (HOHA) COVID-19 infections and 11 Hospital Onset Probably Associated (HOPA) COVID-19 infections. • Maternity - May saw an increased birth rate with obstetric and medical complexity remaining high. Staffing remained challenging with sickness and covid isolation, along with lead in times for recruitment start dates for band 5 and band 6 midwifery posts. Caesarean section rates were static at 28.7% and excellent performance continues in antenatal bookings with 98.25% of women referred being booked by 12 weeks and 6 days. • FFT- Operational pressures in our Emergency Department and increased waiting times continue to impact our FFT positive response. Performance for Emergency Department (68.3%), Maternity Antenatal (50%) and Maternity (Delivery) 79.2% were non-compliant. Inpatient, Community and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good“.	• Resus training compliance is still struggling to improve despite the team’s best efforts. Ongoing review of the Training Needs of all Trust staff and anticipate completing this project by the end of June. It is anticipated that both ALS and ILS compliance will rise significantly following implementation, but BLS will drop • All category 3 and above pressure ulcers undergo root cause analysis to identify any learning. Continued review of rapid response reports with wards and support of individualised action plans. Senior nurse Pressure Ulcer Prevention workshops continue. • National COVID-19 data submissions continue to be validated daily and signed off by the Site Chief Nurse. The Trust, • Maternity –Caesarean section rates were static in May and where we would expect our rate to be and is considered in the context of our other clinical outcome KPIs. • Working towards transforming our services in line with Continuity of Care (CoC) targets. Following confirmation of 100% compliance for the OCKENDEN immediate and essential requirements a site visit from the Regional teams, occurred on May 12th 2022 and 100% compliance was confirmed.

Executive Summary – May 2022 (2 of 2)

	What the Information tells us	Actions and Quality Improvement Projects
Process Perspective	Four Hour Operating Standards for May • Performance against the Four Hour Operating Standard remains challenged with 73.9% of patients either discharged, admitted or transferred within four hours of their arrival • 471 patients breached the 12-hour ED target April Cancer performance • 14 Day Performance increased to 79.8% driven by improvements within Breast. • 62 Day Performance was 71.7% against a target of 85%, backlog recovery ahead of trajectory. • Faster Diagnosis Standard (FDS) continued to meet target with 77.7% of patient's receiving a communication within 28 days following referral Six week diagnostic standard for April • At the end of May 1.5% of patients were waiting for more than six weeks for their diagnostic test compared to 2.4% in April. • Capacity challenges continue within Cardiac MRI accounting for 60% of the total six week breaches. Referral to Treatment for April: • 911 patients have been waiting over 52 weeks since referral for treatment, this is an increase of 65 patients compared to March, impacted by increasing volume of patients on the non admitted PTL. • 62 patients were on the PTL waiting over 78 weeks for treatment this is against a trajectory of 30 patients. The main cohort are within General Surgery, Cardiology and Plastics • April was a challenging month for activity with the reduction in working days impacting on the number of clock stops and removals.	Four Hour Operating Standards actions • Trust is continuing to work with system partners to reduce the number of patients waiting for social services • ED Length of Stay Reviews as well as Daily matron reviews being undertaken • Maximising in/out space for doctors to see patients whilst the number of Decision-to-Admits (DTAs) remain high • Inter Professional Standards meetings with Specialties to review existing guidelines and agreements regarding patient pathways and to deepen existing working relationships continue Cancer • The Cancer improvement Programme 2023/24 will focus on a number of priorities including The delivery of best practise timed pathways to facilitate earlier triage and increase straight to test, Improving Multidisciplinary Team (MDT) working, Pathology and radiology expansion and deliver and sustain the faster diagnosis standard Diagnostics • Additional MRI capacity with new MRI mobile unit from September. In the interim looking to provide Cardiac MRI capacity on existing capacity where possible to manage clinical risk.. • Demand increased through May for Stress Echo – reviewing possible ad-hoc capacity to limit impact in June Referral to Treatment • Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London. • All services will reforecast 52 week breach position to understand the ongoing level of risk. Most significant challenges and growth in ENT, Plastics and Cardiology.
People Perspective	• Sickness rate was 3.9% against a target of 3.2% • In May the Trust vacancy rate was 9.9% which is below the threshold of 10%. • Non-Medical and Medical appraisal rates were both below the target of 90%. A slight increase was seen in performance for both, with performance for the month at 71.2% and 81.9% respectively. • Trust turnover rate at 17.1% in May against a target of 13%, a decrease of 1.2% on last month • Trust Stability performance fell to 79.01% against a target of 85%, the second month of non- compliance. In the last 12 months this has always been compliant. • At time of writing, the COVID-19 vaccination rate was 86.3% compared to 87.6% last month.	• HR continues to work with managers to support staff on long and short term sickness. Support includes, identifying support for staff to improve attendance levels and developing a toolkit to support staff who are off sick and returning after sickness absence. • A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals • Reviewing the complete recruitment process and dovetailing this with retention plans. • Human Resources Business Partners are focussing on the top 10 vacancies as part of the workforce improvement plan and the hard to recruit areas. • A Living Our Values subgroup has been set up to further discuss and engage with staff on the behaviour framework as well as subsequent workshops and materials. • There is an active communication plan promoting vaccinations for staff.

Balanced Scorecard Approach

OUR **OUTCOMES**	How are we doing?					
OUR **PRODUCTIVITY** PERSPECTIVE	Activity Summary	Outpatient Productivity	Theatre Productivity	Bed Productivity		
OUR PATIENT PERSPECTIVE	Patient Safety	Infection Control	Mortality	Readmissions	Maternity	Patient Voice
OUR **PROCESS** PERSPECTIVE	Emergency Flow	Cancer	Diagnostics	On the day cancellations	18 Week Referral to Treatment	
OUR PEOPLE PERSPECTIVE	Workforce	Culture	Agency Use			

Scorecard RAG rating based on PreCOVID-19 plan

Activity Summary

		Activity compared to 2019/20			Activity compared to previous year			Activity compared to 2021/22		
		May-19	May-22	Variance	YTD 19/20	YTD 21/22	Variance	May-21	May-22	Variance
ED	ED Attendances	14,759	13,488	-8.61%	28,604	25,766	-9.92%	12,750	13,488	5.79%
Inpatient	Non Elective	4,187	3,131	-25.22%	8,210	6,026	-26.60%	3,394	3,131	-7.75%
	Elective & Daycase	5,561	4,868	-12.46%	10,439	9,363	-10.31%	5,147	4,868	-5.42%
Outpatient	OP Attendances	50,582	53,162	5.10%	100,206	98,654	-1.55%	48,750	53,162	9.05%

>= 2.5% and 5% (+ or -)
>= 5% (+ or -)

Note: Figures quoted are as at 10/06/2022 and do not include an estimate for activity not yet recorded e.g. Un-cashed clinics, To Come In's (TCI's).

Activity levels for May 2022 have been shown against activity levels reported in May 2019

For reference the grey boxes compare activity levels to May 2021

Outpatient data above **excludes COVID-19 activity** (Activity data presented above is based on Finance definition of POD1).

May Activity Performance v Plan – Elective, Daycase & OP

The Trust has submitted a final activity plan for 2022/23; this is equivalent to 90% of 2019/20 levels adjusted for working days for April, 96% for May and 100% thereafter. An internal plan has additionally been approved based on bottom-up planning with individual clinical specialties. Therefore the internal and external plans do not reconcile.

Note: The below activity information is shown in 'SLAM' currency, as this is the currency the Trust is used to seeing and reporting.

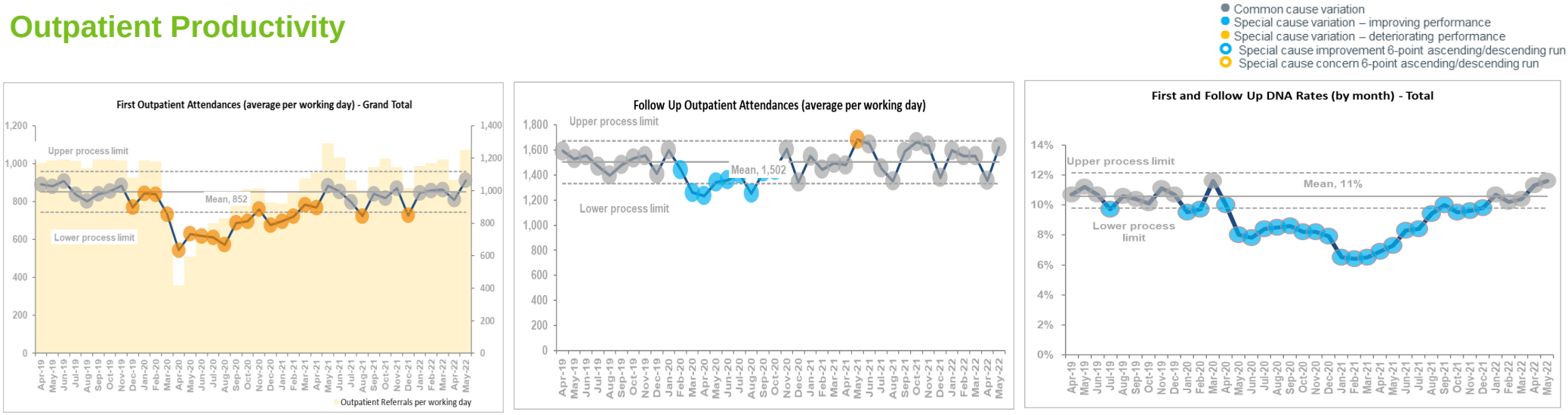
	ACTIVITY QUANTUMS - MAY						ACTIVITY %s vs 19/20				
Specialty	May WD Adj 19-20	Plan	Activity	Catch Up Estimate	Activity After Catch Up	Variance to Plan	Plan	Actual	Catch Up Estimate	Activity After Catch Up	Variance to Plan
Cardiac Surgery (172)	36	20	31	1	32	12	54%	86%	1%	88%	33%
Colorectal Surgery (104)	52	57	24	2	26	-31	110%	46%	4%	50%	-60%
Ear, Nose & Throat (ENT - 120)	162	167	139	14	153	-14	103%	86%	9%	95%	-8%
General Surgery (100)	78	66	75	6	81	15	84%	96%	8%	104%	19%
Gynaecology (502)	226	203	184	16	200	-4	90%	81%	7%	88%	-2%
Neurosurgery (150)	169	145	151	9	160	15	86%	89%	5%	95%	9%
Trauma & Orthopaedics (110)	158	112	93	10	103	-9	71%	59%	6%	65%	-6%
Urology (101)	280	312	353	37	390	78	111%	126%	13%	139%	28%
Total Theatre Specialties	**1,161**	**1,081**	**1,050**	**94**	**1,144**	**62**	**93%**	**90%**	**8%**	**99%**	**5%**
Gastroenterology (301)	1,525	1,206	1,044	152	1,196	-10	79%	68%	10%	78%	-1%
Cardiology (320)	253	237	209	6	215	-22	94%	83%	2%	85%	-9%
Dermatology (330)	16	10	4	0	4	-6	65%				
Neurology (400)	714	663	678	31	709	46	93%	95%	4%	99%	6%
Paediatrics (420)	25	33	52	4	56	23	133%	208%	16%	224%	91%
Paed Surgery (171)	104	86	89	4	93	7	82%	86%	4%	89%	7%
Clinical Haematology (303)	16	149	174	58	232	83	932%	1088%	366%	1453%	521%
Medical Oncology (370)	68	101	104	2	106	5	148%	153%	3%	156%	7%
All Other Specialties	1,679	1,620	1,464	73	1,537	-83	96%	87%	4%	92%	-5%
Total Non-Theatre Specialties	**4,400**	**4,105**	**3,818**	**331**	**4,149**	**44**	**93%**	**87%**	**8%**	**94%**	**1%**
Balancing Figure to Ext Plan		**152**					**3%**				**-2%**
Total Daycase / Elective	**5,561**	**5,339**	**4,868**	**425**	**5,293**	**-46**	**96%**	**88%**	**8%**	**95%**	**-1%**
Outpatients	**50,582**	**48,559**	**53,162**	**2,658**	**55,820**	**7,261**	**96%**	**105%**	**5%**	**110%**	**14%**

This table shows performance against the elective and day case activity plans split between theatre specialties and other specialties. It also shows Outpatient performance as a Trust. Diagnostic mapping to ascertain performance against trajectories is being worked through with commissioning colleagues.

Elective and Daycase performance is expected to be behind plan (after estimated catch up), with a percentage of 95%, lower than the 96% plan submitted for May.

Outpatient performance is expected to be 110% after catch-up, which is higher than the 96% plan.

Outpatient Productivity



What the information tells us

Throughout May the Trust saw an increase in the number of outpatient referrals, receiving on average 1,251 per day. Total outpatient activity was at 105% of levels reported in May 2019, this is above target of 96% and expected to increase to 110% once data catch up is complete.

First outpatient attendances per day increased and while remaining within the upper and lower control limits this is the highest month for activity reported since pre-covid. Increases seen throughout the majority of specialties, mainly being driven by ENT and Plastic Surgery.

Follow-up activity remains within the upper and lower control limits seeing on average 1,622 attendances per day.

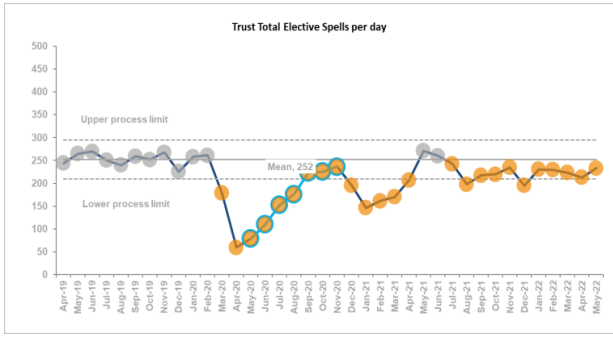
DNA rates although remaining within the upper and lower control limits is seeing a rising trend with 11.6% of patients not attending their outpatient appointment in May, this is in line with increased activity.

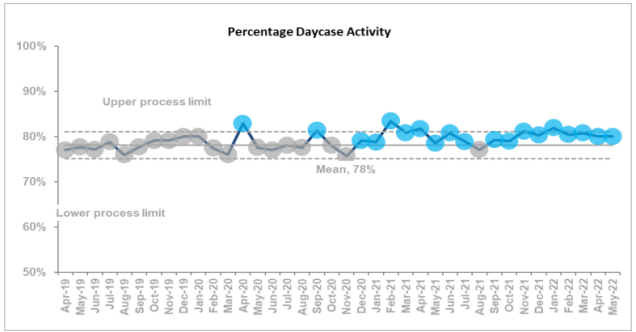
Please note that COVID-19 related OP activity has been excluded from the charts

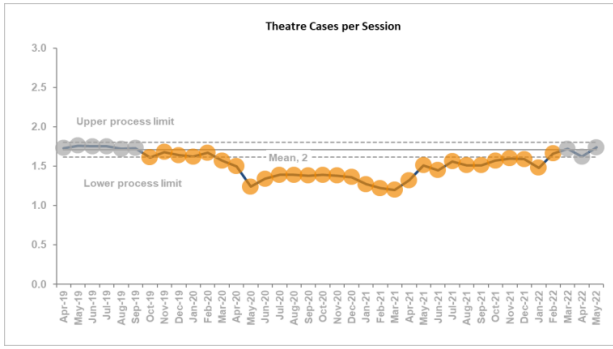
Actions and Quality Improvement Projects

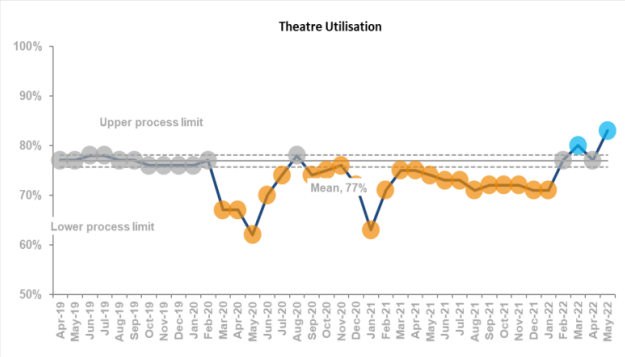
- With some clinic space returning to us in July we are commencing a piece of work to understand the needs of Services and clinical urgency. We are also starting to audit the use of rooms to understand where clinic space is being used for virtual activity i.e. telephone clinic, and then work with the services to revise their templates to free up space for face to face activity and will continue to work with Estates to create a Virtual Clinic Hub enabling clinicians to deliver virtual activity in an appropriate environment.
- Additional clinics to address the large number of patients referred via the Two Week Rule pathway are being undertaken, including telephone clinics at weekends and this will likely contribute to an increase in the number of patients that can be seen.
- As part of the Trust's Green Plan we will be working to encourage a change in culture to more virtual activity be that video or telephone, and all Care Groups will be encouraged to review their Outpatient clinical pathways with a view to re-designing with this in mind. Once we have a Virtual Clinic Hub services will be encouraged to review their templates again to separate out their face to face and virtual activity so we can maximise the use of our physical space for patients that need to be seen in the F2F environment.
- The launch of the Patient Portal will support patients to be more invested in their care and we hope to use it to support the roll our of Patient Initiated Follow-up (PIFU) which should help to decrease the number of f/up appointments thus enabling an increase in New appointments which will support out ECRP. We will also start to look at implementing the paper letter opt out option which will provide a cost saving to the Trust and support the Trust's Green Plan.

Elective Activity & Theatre Productivity









What the information tells us

On average throughout May, 233 patients were treated per day compared to 213 in April, seeing a positive increase. Activity levels were 93% of May 2019 against a target of 96%. This is expected to increase to 95% once data catch up is complete. Increases in the month were driven by Endoscopy and Neurology and supported by a significant improvement in utilisation rates.

In May, Theatres ran a total of 1,955 theatre lists (elective and non elective sessions), compared to 1,674 in the same period in 2019 .

- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

Actions and Quality Improvement Projects

Anaesthetic recruitment

- A key 'rate limiting step' for Theatre capacity has been the high rate of resignations, retirements and long term sickness rates that have reduced the anaesthetic workforce by 25% (since July last year – 21 Anaesthetic consultants and Specialty Doctors have left the Trusts).
  - To fill these vacancies over 30 adverts have been put out to attract new recruits.
  - 16 Anaesthetic consultants and Specialty Doctors have been successfully recruited as a result.
  - 6 agency locums have also been recruited and deployed to help fill gaps (plus Xyla staffing at QMH). A further 3 are being onboarded over the next fortnight.
  - 10 more posts are currently (or imminently) out to advert.
    - Paeds (2 x consultants)
    - Cardiac (2 x substantive, 1 x locum)
    - Neuro (1 x locum, 1 substantive)
    - Hybrid (1 x substantive - T&O)
    - Hybrid (2 x substantive - General)
  - Dates have been set for interviews for 7 posts over the next two months.

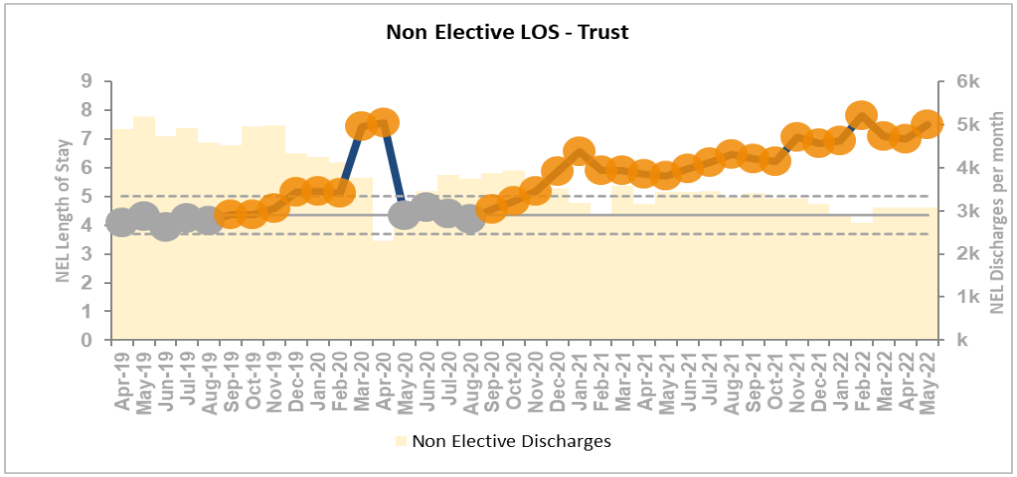
Theatres Transformation Board (TTB):

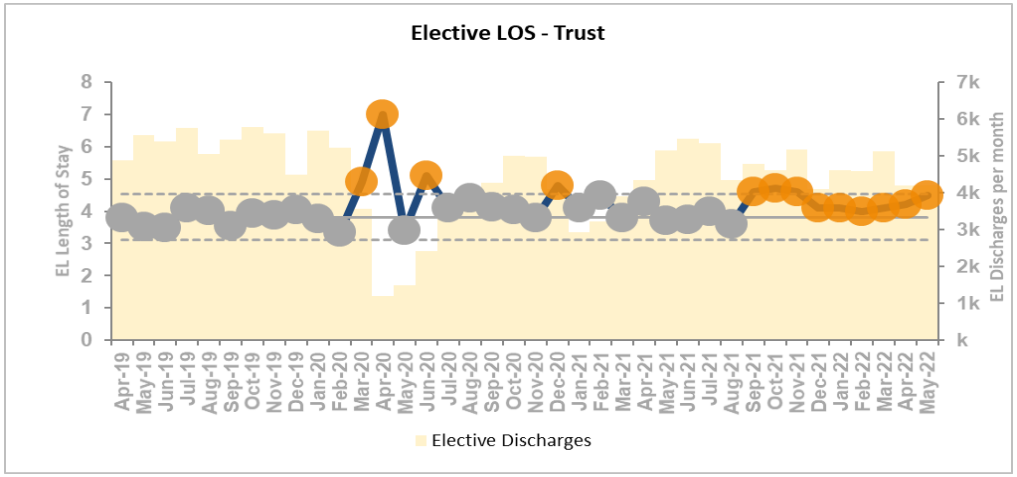
- The first TTB took place on Tuesday 14th June. The following priorities were identified for focus and further discussion at the next meeting:
  - Agreeing a 'Theatre Charter' which sets expectations around timings of key activities during the day, to improve productivity.
  - Focusing on driving up QMH theatre utilisation ('in list' productivity) and plant utilisation (session 'pick up').
  - Specialty productivity focus: Plastics and Gynaecology.
  - Procurement update – delayed delivery of consumables and equipment.

ODP Working Group

- High vacancy rates in our ODP workforce presents a growing risk to the Trust's ability to staff lists. Over the last three years the ODP substantive workforce has fallen by 37%, with bank and agency filling the gap which has increased costs and created risks around on call staffing etc.
- A working group was launched in October to tackle these issues and is now implementing a range of recommendations around pay, on call/ night shifts, breaks, improved bank pay for permanent staff, recruitment and retention initiatives and a new culture and behaviours survey to identify issues.

Length of Stay





Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

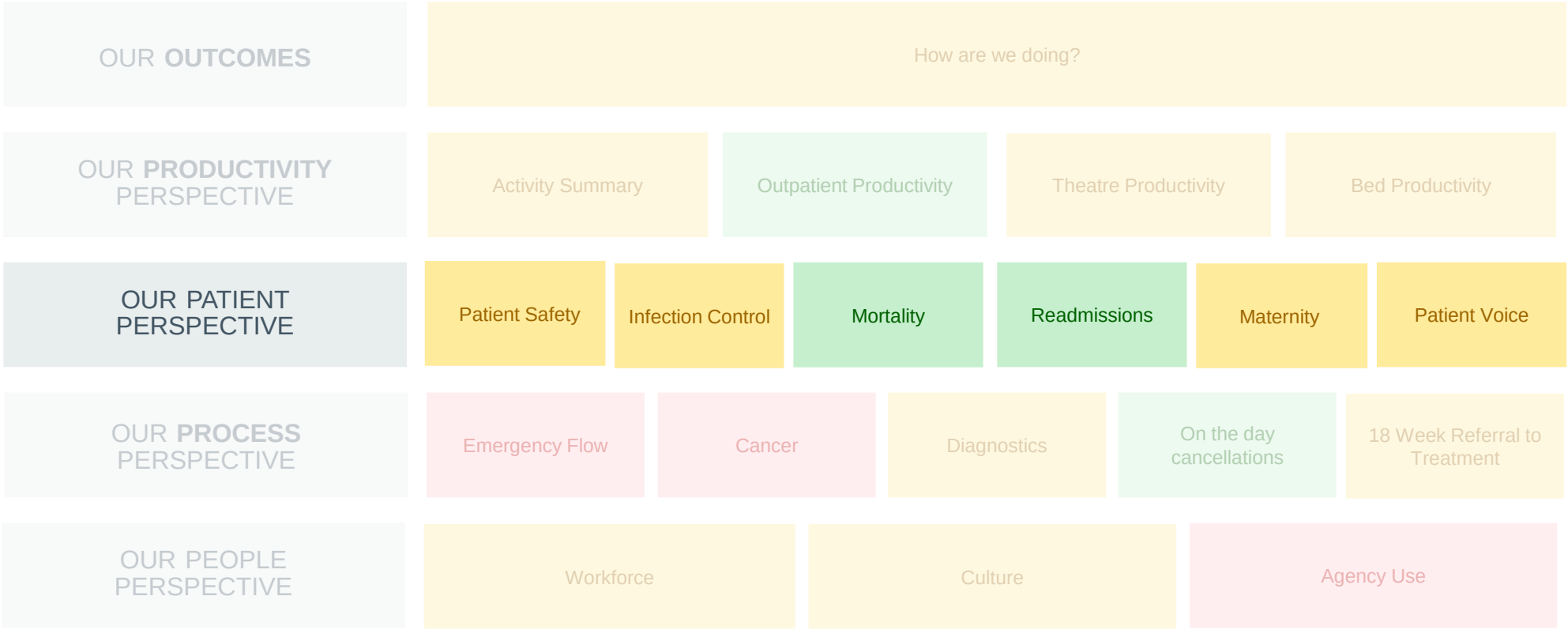
Non-elective length of stay remains above the upper control limit and 2019 baseline. On average through May patients stayed in a hospital bed for 7.5 days. The increasing trend continues to be driven by Acute Medicine and Senior Health. Total non-elective admissions increased by four patients per day compared to April. Patients requiring emergency care continue to present with higher acuity compared to pre-covid and the Trust continue to see a high number of medically fit patients awaiting discharge with a high proportion of patients already having a length of stay for more than 21 days however at time of writing, June performance has seen a positive reduction in the number of super stranded patients.

Elective length of stay is showing a slow but steady increase remaining above the mean. On average, patients stayed in a hospital bed for 4.5 days in May.

Actions and Quality Improvement Projects

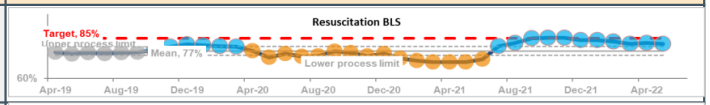
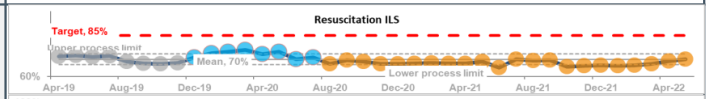
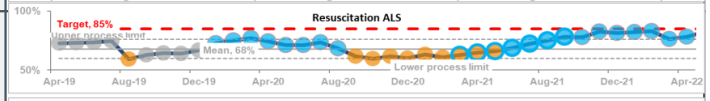
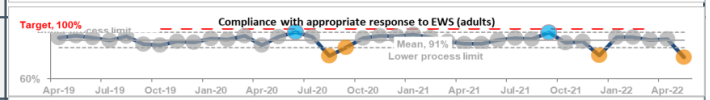
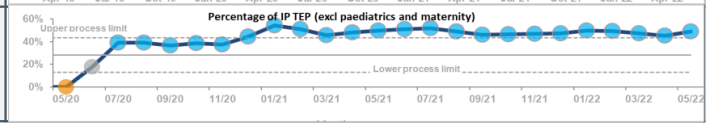
- Work to optimise Discharge to Assess process with Merton and Wandsworth underway to ensure there is a reduction in the number of rejected D2A's and effective use of care support, placements and rehabilitation beds.
- Review of the stranded patient weekly call ToR and function underway with Merton and Wandsworth
- The Departure Lounge improvement project is underway with a view to increase the capacity and utilisation of the lounge
- External interface flow work which includes three focal areas for Merton and Wandsworth: discharge, maximising community capacity and virtual frailty ward (Hospital at Home). Additional central funding for virtual ward for Merton and Wandsworth allocated
- Focus on improving compliance with Red2Green to reduce internal delays for pathway 1-3 patients
- MedCard discharge SWAT team fully recruited to and working in conjunction with the Transfer of Care Team (TOC) to optimise flow. TOC team manager in post.
- Focus on improving the number of weekend discharges

Balanced Scorecard Approach



Quality Priorities – Deteriorating Patients

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

	Target	May-22	Var to target	Trend
Basic Life Support Training (BLS)	85.0%	81.6%	-3.4%	
Immediate Life Support Training (ILS)	85%	70.4%	-14.6%	
Advanced Life Support Training (ALS)	85%	82.1%	-2.9%	
Compliance with appropriate response to Early Warning Scores (Adults)	100%	77.2%	-22.8%	
Percentage of Inpatient Treatment Escalation Plans (excl paediatrics and maternity)	40%	49.8%	+9.8%	

What the information tells us

- BLS (Basic Life Support) training performance continues to shows special cause improvement , with performance at 86.1% although still below target.
- ILS (Immediate Life Support) shows special cause deterioration, with performance slightly improved on last month at 70.4% this month.
- ALS (Advanced Life Support) training performance increased to 82.1%.
- Compliance with appropriate response to Early Warning Score (EWS),fell from 91.5% in April to 77.2% in May and now shows special cause variation with a deteriorating position.
- Performance against our Treatment Escalation Plans has plateaued however continues to be above the long-term mean and show common cause variation with an improving position.

Actions and Quality Improvement Projects

Resus training compliance is still struggling to improve despite the team's best efforts. Ongoing review of the Training Needs of all Trust staff and anticipate completing this project by the end of June. Predicted that both ALS and ILS compliance will rise significantly following implementation but BLS will drop. Plan to provide targeted training including taking the manikins out to departments to try and recover this drop quickly.
There will be the introduction of an enhanced BLS course for all NQNs, Band 5 nurses who do not take charge and AHPs who are currently allocated ILS. Nursing Associates will also be assigned BLS+. This is a 4 hour course covering BLS with AED, Anaphylaxis, Choking, First Aid for fits/Faints/Falls etc (Recovery position). CCOT will also provide a session on Deteriorating Patient and TEP.
Nursing Staff will be expected to have an ILS before taking charge of the ward environment . Any Staff wishing to complete a higher level of training than allocated will be encouraged to do so if appropriate. This has been discussed with colleagues at ESTH who are considering a similar approach.
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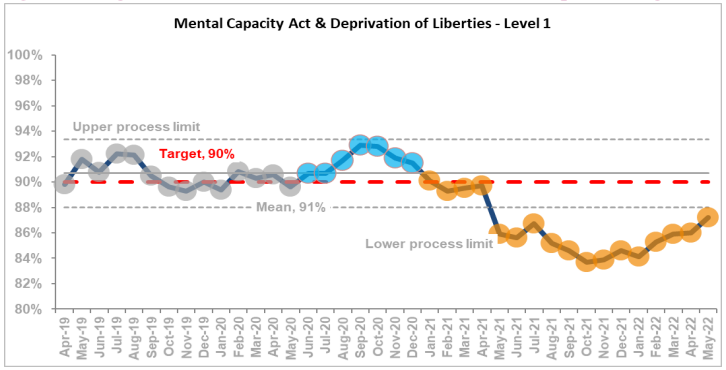
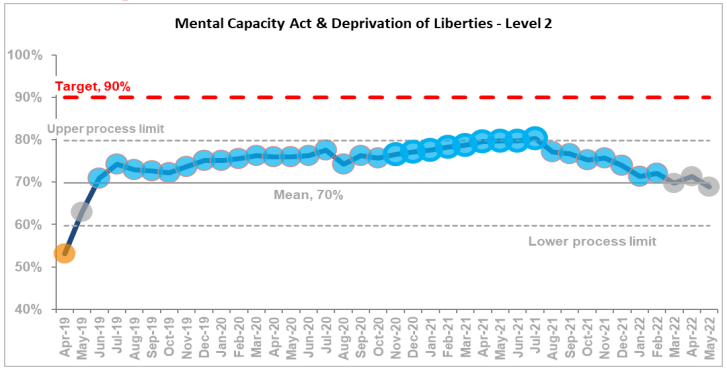
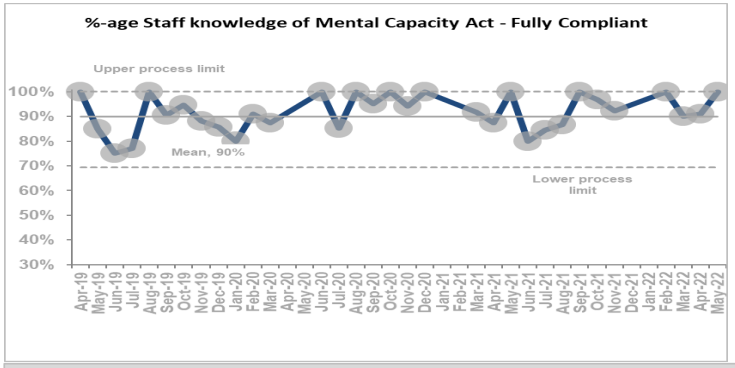
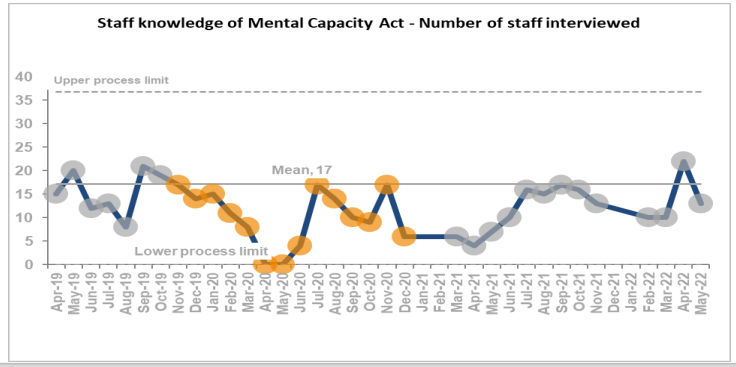
Quality Priorities – Mental Capacity Act & Deprivation of Liberties









Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

What the information tells us

- Mental Capacity Act and Deprivation of Liberties (MCA/DoLs) Training – Performance in May for Level 1 was 87.2% and shows special cause variation with a deteriorating performance. The past year has been below the 2019/20 average.
- Overall Level 2 compliance increased to 71.3%, compared to 68.9% last month and continues to show common cause variation.
- Performance for the number of staff interviewed and their level of knowledge shows commons cause variation. These metrics were suspended in December 21 and January 22.

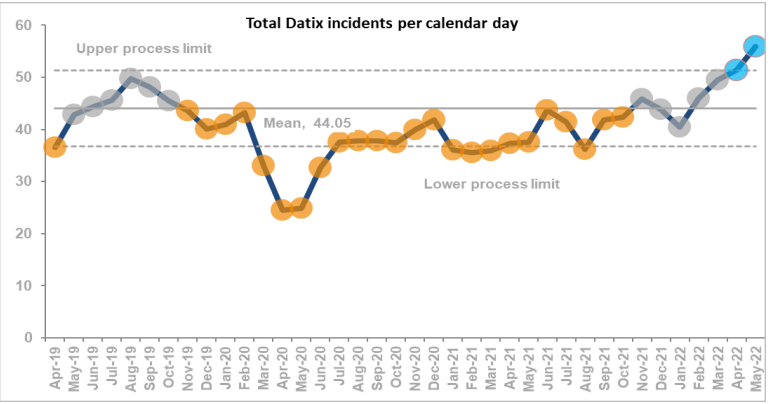
Actions and Quality Improvement Projects

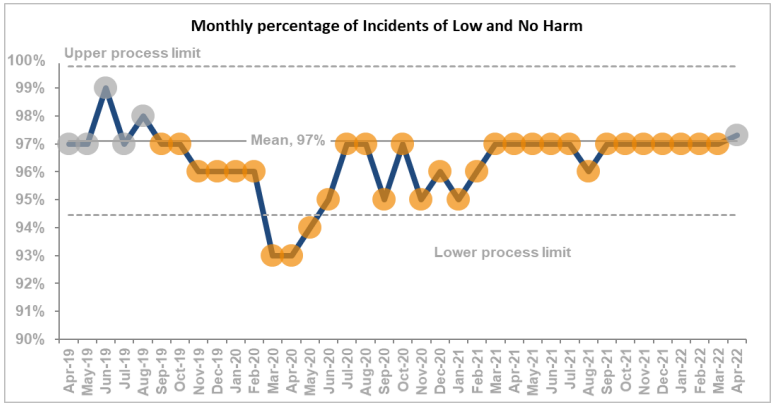
MCA DoLs Level 2 training has marginally increased since May 2022, however as existing Level 2 training falls out of the initial 3 year period, ongoing concerted input is required across Divisions. Level 1 training has slightly increased. Despite ongoing contact with staff, ability to organise bespoke sessions and easy online access to the requisite training, non-compliance for Level 2 continues to sit within the Medical Dental Group, mainly Specialty Registrars and Junior Doctors. The MCA team have emailed all Junior Doctors sitting within Corporate Division, however Divisional input is required to reach the wider cohort of Trainee's.
The Governance Leads and MCA team meet every 2 months to understand risks within Divisions and how the MCA & Safeguarding team can support. A core focus is requesting that each Division focus on MCA training to improve patient experience and reduce risk of CQC censure & reputational damage and potential litigation costs.
A Pilot Level 3 MCA training is being undertaken in partnership with Neuro Rehab. This is part of our Liberty Protection Safeguards(LPS) preparation and will support seeding additional knowledge Trust wide, due to the Allied Health Professional rotation programmes.
The London Clinical Reference Group for the Liberty Protection Safeguards (LPS) is holding a workshop on Thursday 16th which includes a focus group for Acute Providers. This will provide an opportunity to fully inform our LPS response and understanding of the impact on the Trust.

Quality Priorities – Learning from Incidents

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

Indicator Description	Threshold/ Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Monthly percentage of Incidents of Low and No Harm		97.0%	97.0%	97.0%	96.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.0%	97.3%	data one months in arrears
Open SI investigations >60 days	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Duty of Candour completed within 20 working days, for all incidents at moderate harm and above	100%	100.0%	96.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	94.0%	97.0%	data two months in arrears	
Total Datix incidents per calendar day		38	44	42	36	42	42	46	44	40	46	50	51	56





What the information tells us

- All Open Serious Incident (SI) investigations are being completed in line with external deadlines of 60 working days.
- There was a failure to achieve 100% compliance with DOC within 20 working days for the month of February 2022. March's performance was much improved at 97% as anticipated.
- There were a total of 56 Datix incidents per calendar day this month.

Actions and Quality Improvement Projects

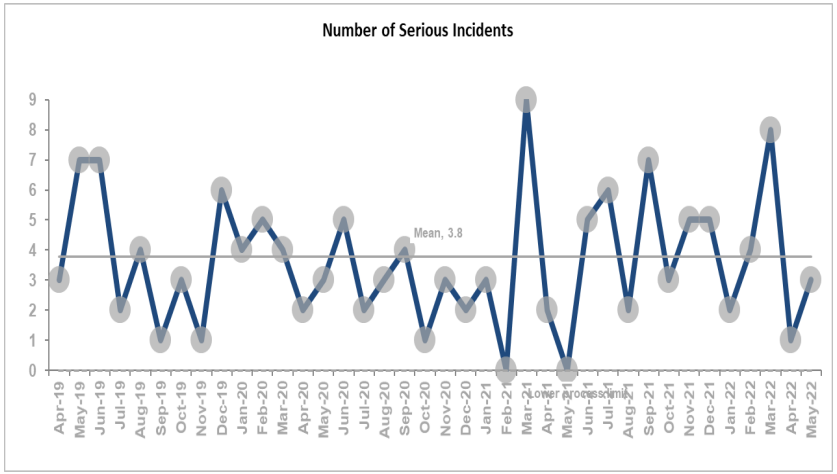
Duty of Candour (DoC) for January and March was 100% across the 3 Divisions. In February and March a combination of illness and shortage of staff resulted in non-compliance at 94% and 97% respectively against the 100% target.

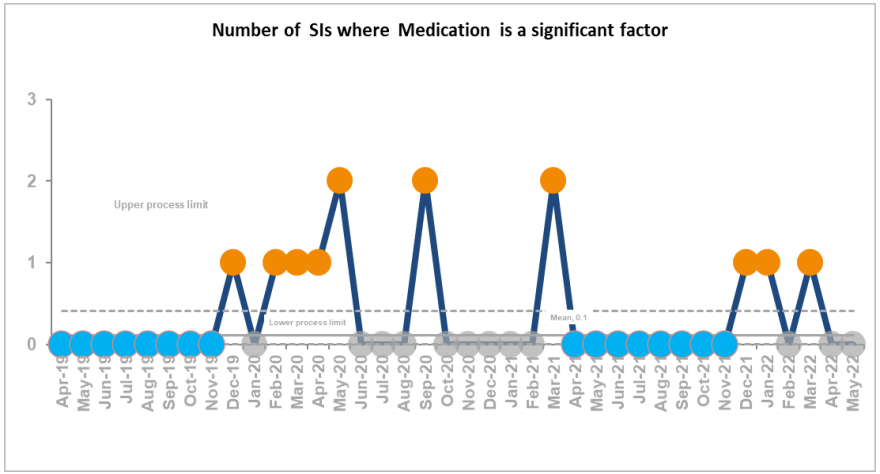
DoC compliance continues to be monitored and support provided to the relevant departments in order to achieve compliance.

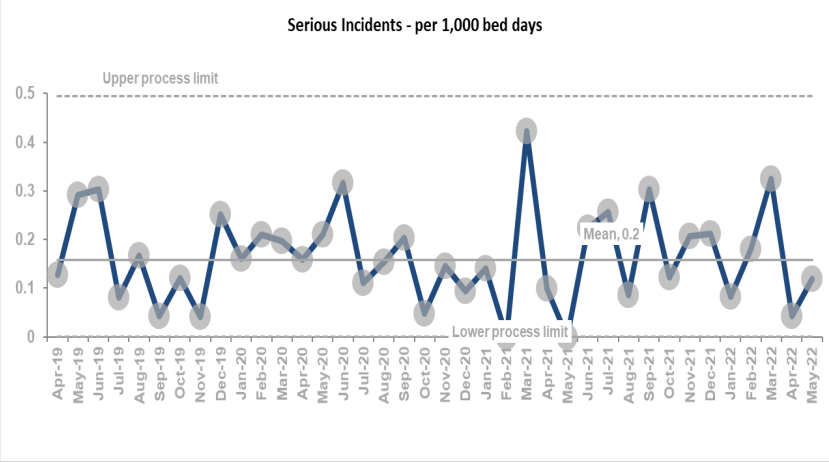
Our Patient Perspective

Patient Safety- Serious Incidents

Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run







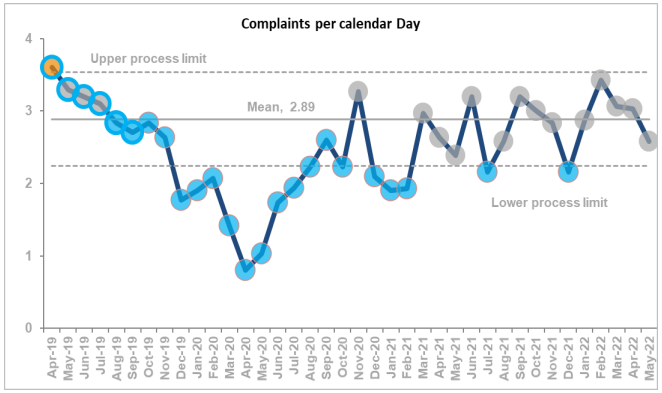
What the information tells us

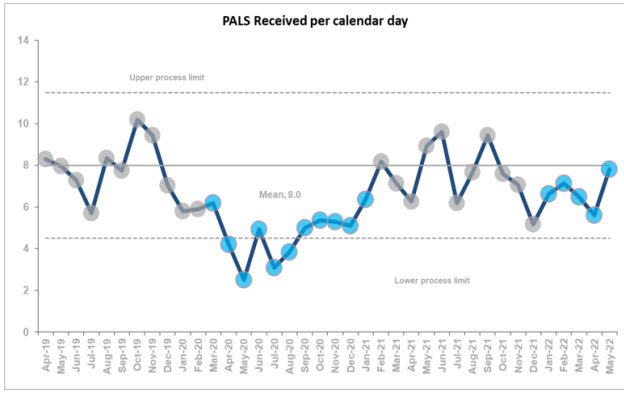
- Common cause variation is seen in the number of Serious Incidents and the number of Serious Incidents per 1,000 bed days.
- No Serious Incidents where Medication is a significant factor was recorded in May, now showing common cause variation.

Our Patient Perspective

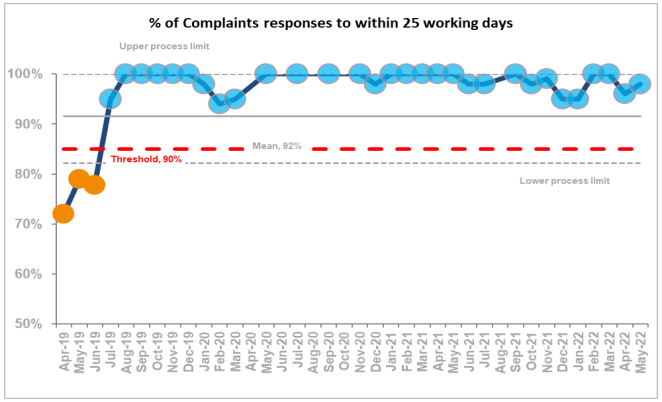
Complaints

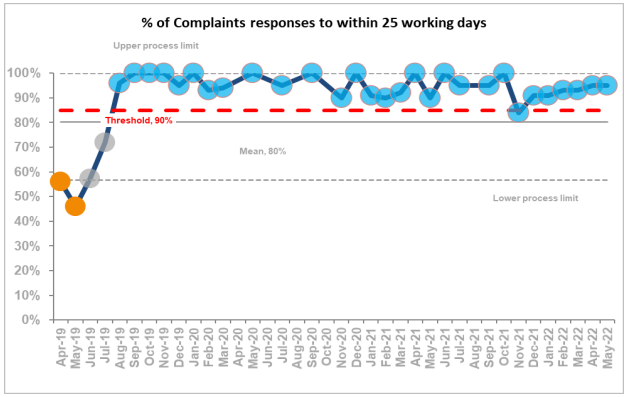
Indicator Description	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Complaints Received per calendar day		2.4	3.2	2.2	2.6	3.2	3.0	2.8	2.2	2.9	3.4	3.1	3.0	2.6
% of Complaints responses to within 25 working days	85%	100%	98%	98%	98%	100%	98%	99%	95%	95%	100%	100%	96%	98%
% of Complaints responses to within 40 working days	90%	90%	100%	95%	94%	95%	100%	84%	91%	91%	93%	93%	95%	95%
% of Complaints responses to within 60 working days	100%	100%	50.0%	N/A	N/A	100%	N/A	N/A	67.0%	N/A	100%	100%	100%	100%
Number of Complaints breaching 6 months Response Time	0	0	0	0	0	0	0	0	0	0	0	0	0	0





Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run





What the information tells us

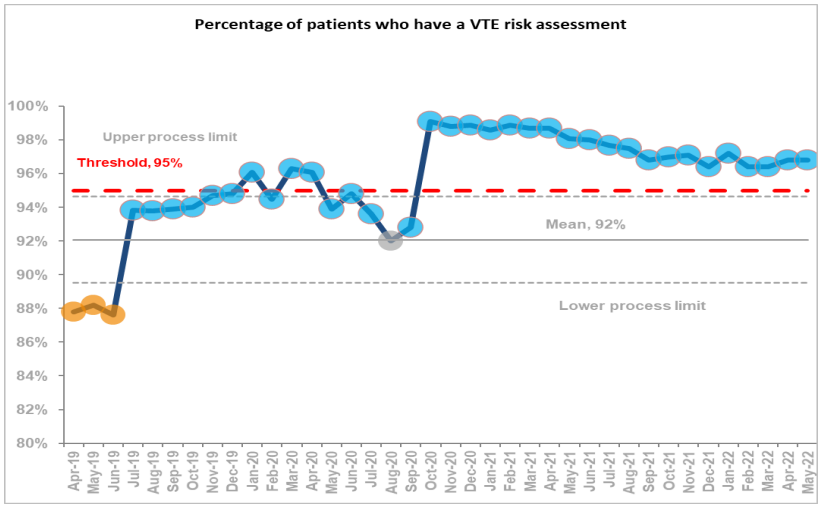
- The number of complaints per calendar day shows common cause variation with the number of formal complaints received decreasing from 91 to 90 in May2022.
- Percentage of complaints responded to within 25 working days was achieved with performance at 98%.
- Percentage of complaints responded to within 40 working days was achieved with performance at 95%.
- Two complaints were not responded to within 60 working days.
- PALS received per calendar shows special cause variation with an improving position.

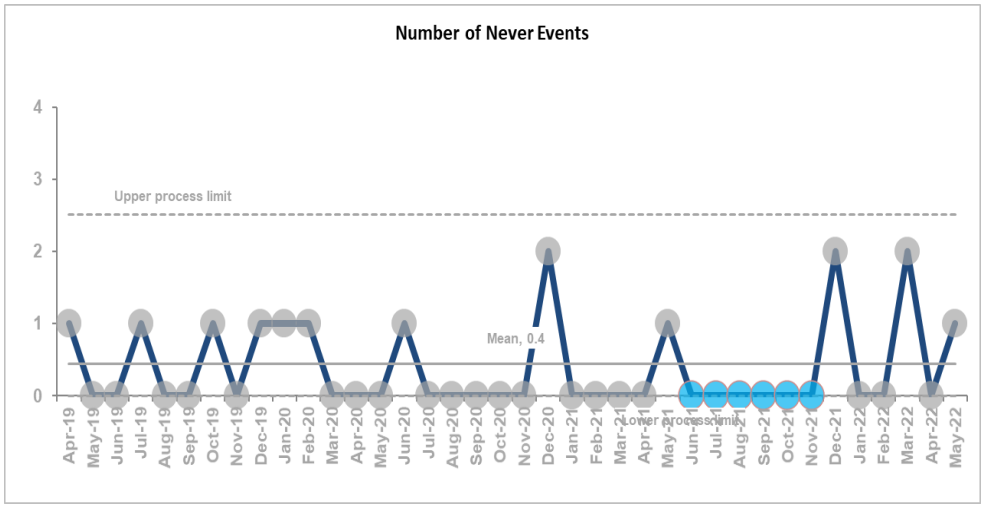
Actions and Quality Improvement Projects

The daily complaints comcell continues to maintain the focus on sustained performance across all responses categories.

Our Patient Perspective

Patient Safety- VTE and Never Events





What the information tells us

- In May 96.2% of patients had a VTE completed within the required time frame with performance continuing to be above the upper control limit.
- There was one Never Event declared in May 2022

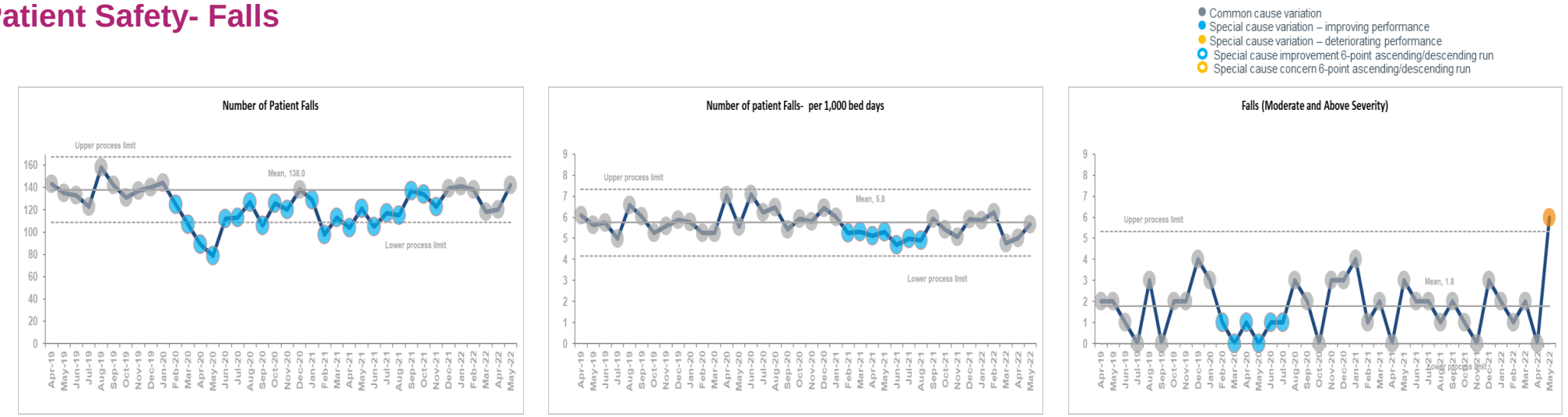
Actions and Quality Improvement Projects

VTE The Hospital Thrombosis Group (HTG) continue to monitor VTE performance through Tableau reporting, the pharmacy VTE audit and hospital acquired thrombosis root cause analysis. The COVID-19 VTE prophylaxis policy has also been updated based on NICE guidance published in September 2021.

All Never events

Our Patient Perspective

Patient Safety- Falls



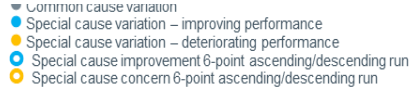
What the information tells us

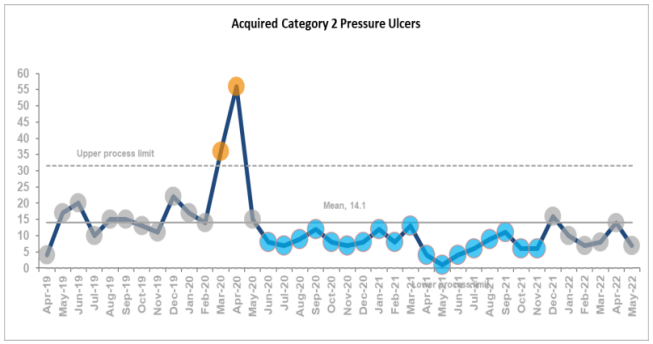
- Overall fall rates remain lower than average, reporting 142 falls in May
- Fall rates per 1,000 Occupied Bed Days are currently at 5.66 with performance showing common cause variation
- There were 6 moderate or severe falls, increasing above the upper control limit for the first time in 2 years

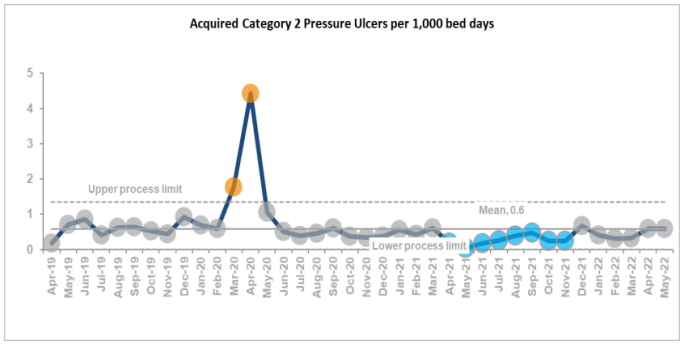
Actions and Quality Improvement Projects

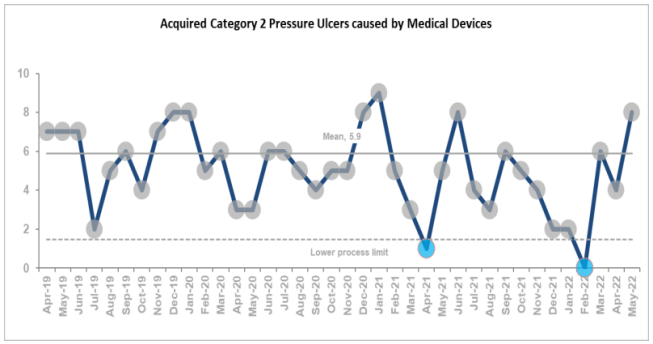
- Falls prevention measures continue to be implemented across inpatient wards
- Falls incidents continue to be monitored and reviewed locally by senior nursing teams with any learning identified and improvement actions implemented as appropriate.
- Wards identified as 'hot-spot wards` [due to reporting higher number of falls than usual], are working to improve falls prevention within their areas. The Moderate harm fall in May occurred outside the 'hot-spot' areas. In response to the moderate harm falls, local leaders are working with staff to avoid similar incidents happening in the future. Learning plans are overseen by the local governance teams

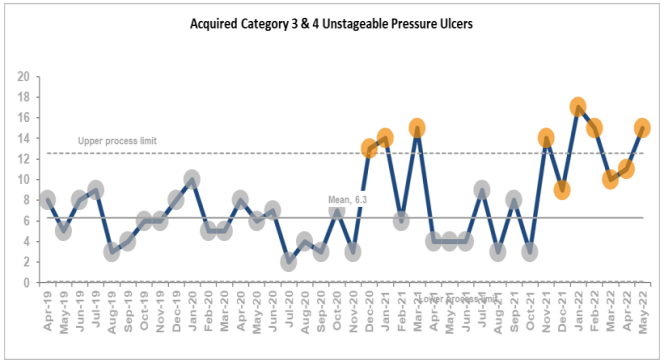
Patient Safety- Pressure Ulcers

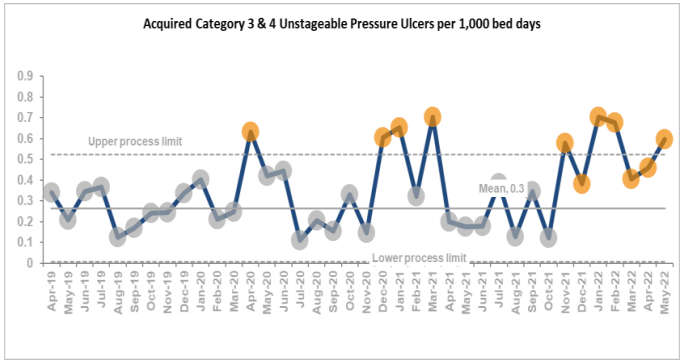


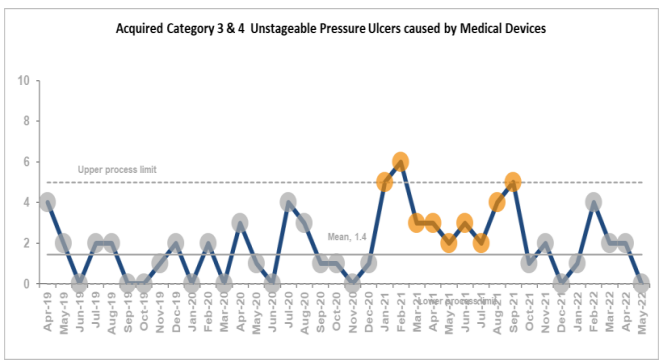












All PUs exclude Medical Devices except where stated

What the information tells us

- There were 7 Acquired Category 2 Pressure ulcers this month. Acquired Category 2 PUs and rate per 1,000 bed days shows common cause variation.
- There were a total of 15 Category 3 & 4 Unstageable Pressure ulcers this month. The rate per 1,000 bed days show special cause variation with a deteriorating position and those caused by Medical Devices show common cause variation.

Actions and Quality Improvement Projects

- All category 3 and above pressure ulcers undergo root cause analysis to identify any learning
- On-going mandatory and induction teaching sessions occur, with regular visits to QMH.
- Continue the review of rapid response reports with wards and support their individualised action plans.
- Continue Senior nurse Pressure Ulcer Prevention workshops and develop a poster for categories of pressure ulcers in dark skin tones and teach pressure ulcer prevention to newly qualified nurses on preceptorship day

Our Patient Perspective

Infection Control

Indicator Description	Threshold 2022-2023	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22	YTD Threshold
MRSA Incidences (in month)	0	0	0	0	0	1	1	0	0	0	0	0	0	0	0
Cdiff Hospital acquired infections	43	2	2	0	3	4	4	5	5	3	2	1	10	5	18
Cdiff Community Associated infections		0	0	0	2	1	1	1	0	2	1	1	3	0	
MSSA		3	3	3	3	0	3	10	2	4	3	6	1	2	3
E-Coli	93	6	5	6	5	4	5	7	5	5	2	8	9	2	11
Covid-19 Nosocomial Infections Hospital Onset healthcare associated (>14 days) HOHA	N/A	0	0	0	18	2	7	4	69	61	14	47	30	15	45
Covid-19:Nosocomial Infections Hospital Onset Probable associated (8-14 days) HOPA	N/A	1	1	0	10	1	4	1	31	31	17	40	27	11	38
Pseudomonas Aeruginosa	29	0	3	3	1	3	3	1	3	4	1	4	2	2	4
Klebsiella spp. Bacteraemia	76	5	2	4	5	7	4	7	4	3	3	2	3	5	8

What the information tells us

- There were 5 C. difficile infections during May 2022; all 5 were classified as Hospital Onset Healthcare Associated (HOHA), where the specimen was taken beyond admission day plus one day; and 0 were classified as Community Onset Healthcare Associated (COHA), where the specimen was taken within admission day plus one day (and where the patient had also been an inpatient in the previous 4 weeks). There is a NHSIE trajectory of no more than 43 cases for 2022-23. This equates to no more than 3.5 cases per month. This means the year has started significantly above trajectory. A focus on antimicrobial stewardship is planned.
- There were 3 patients with a Trust apportioned MSSA blood stream infection during May 2022. There are no national or local trajectories for MSSA.
- There were 2 cases of Trust apportioned E. coli bacteraemia during May 2022. There is a NHSI/E trajectory of no more than 93 cases for 2022-23. This equates to no more than 7.75 per month.
- There were 2 cases of P. aeruginosa bacteraemia during May 2022 (where the sample has been taken >48 hours beyond admission). There is a NHSI/E trajectory of no more than 29 cases for 2022-23. This equates to no more than 2.4 per month.
- There were 5 cases of Klebsiella spp. bacteraemia during May 2022 (where the sample has been taken >48 hours beyond admission). There is a NHSI/E trajectory of no more than 76 cases for 2022-23. This equates to no more than 6.3 per month.
- There were 15 Hospital Onset Healthcare Associated cases (HOHA) of Covid-19 during May 2022, where the sample was taken >14 days after admission and 11 Hospital Onset Probable Associated (HOPA) cases where the sample was taken 8-14 days after admission.

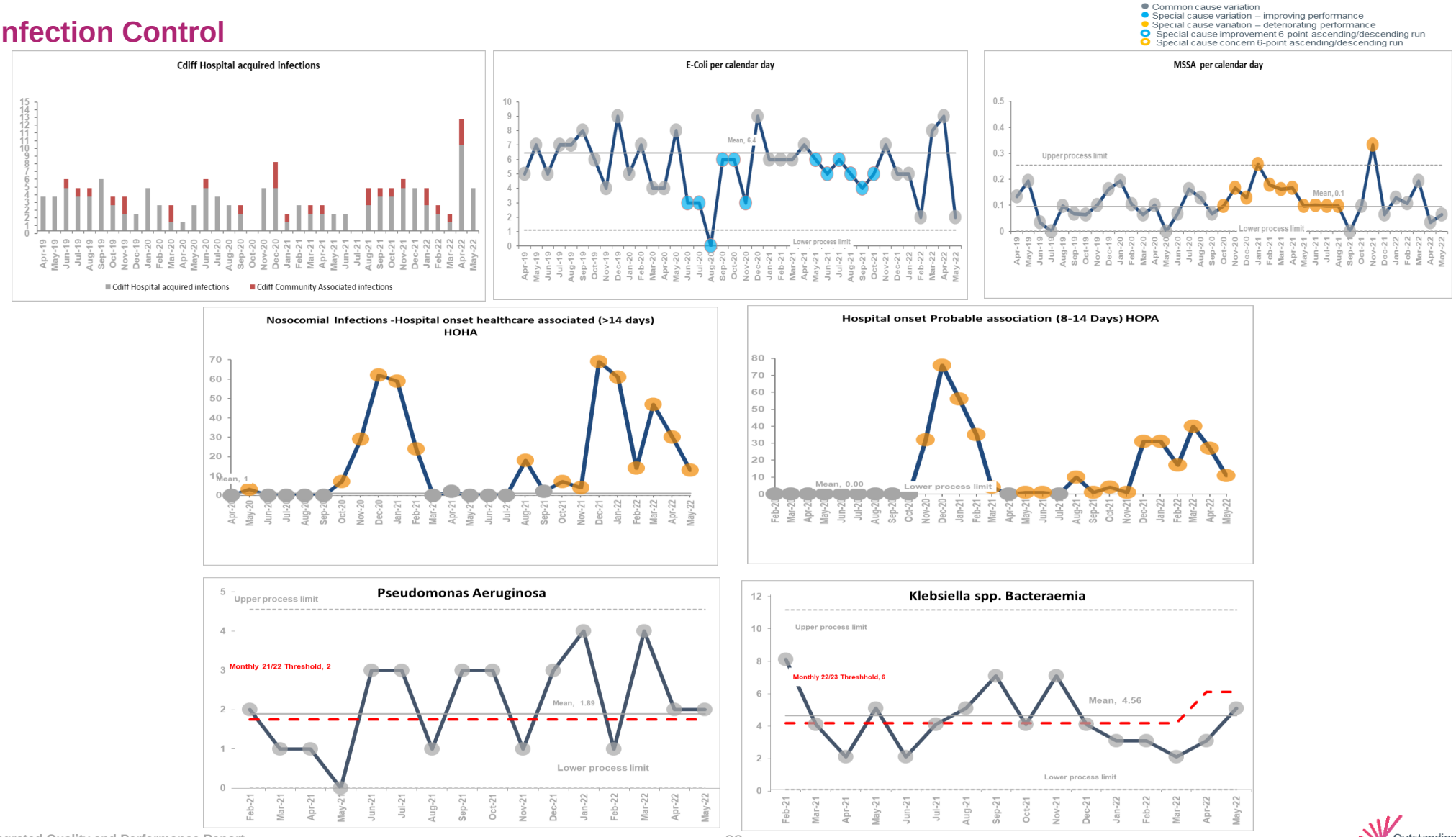
Actions and Quality Improvement Projects

National COVID-19 data submissions continue to be validated daily and signed off by the Site Chief Nurse. The Trust, with IPC support has discontinued day 3 and day 5 post admission screening. Some high risk areas will continue weekly swabbing. Face masks are no longer required outside an agreed designated list of clinical areas; and patients with no respiratory symptoms, including outpatients are no longer required to wear a mask.

This position has been agreed across the St George's and Epsom and St Helier University Hospitals and Health Group.

Our Patient Perspective

Infection Control



Mortality and Readmissions

Indicator Description	Mar-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	Jun-21	Jul-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar 2021 to Feb 22
Hospital Standardised Mortality Ratio (HSMR)	105.8	81.8	59.3	82.7	81.9	75.0	75.7	95.4	85.7	120.9	108.7	108.7	108.7	63.7	63.7	86.8	86.4	88.2	81.2	82.6	83.7	83.0
Hospital Standardised Mortality Ratio Weekend Emergency	102.7	62.7	66.8	91.1	96.3	150.6	127.9	111.8	118.2	141.8	120.9	120.9	120.9	84.7	84.7	105.5	79.9	102.3	75.3	70.4	95.5	92.9
Hospital Standardised Mortality Ratio Weekday Emergency	96.7	87.5	54.7	74.3	77.8	69.2	63.1	86.1	79.6	122.2	107.3	107.3	107.3	76.6	76.6	83.6	87.6	83.1	77.4	84.1	83.7	79.0

Indicator Description	Apr-19-Mar-20	May-19-Apr-20	Jun-19-May-20	Jul-19-Jun-20	Aug-19-Jul 20	Sep-19-Aug-20	Oct-19-Sep-20	Nov-19-Oct-20	Dec-19-Nov-20	Jan-20-Dec-20	Feb-20-Jan-21	Mar-20-Feb-21	Apr-20-Mar-21	May-20-Apr-21	Jun-20-May-21	July-20-June-21	Aug-20-Jul-21	Sep 20-Aug 21	Oct 20-Sep 21	Nov 20-Oct 21	Dec 20-Nov 21	Jan 21-Dec 22
Summary Hospital Mortality Indicator (SHMI)	0.89	0.88	0.88	0.87	0.87	0.85	0.86	0.85	0.86	0.84	0.83	0.83	0.82	0.82	0.85	0.86	0.88	0.89	0.89	0.90	0.90	0.91

Indicator Description	Nov-20	Dec-20	Jan-21	Feb-21	Mar-21	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
Emergency Readmissions within 30 days following non elective spell (reporting one month in arrears)	9.6%	8.9%	10.6%	10.6%	10.0%	9.8%	10.3%	10.3%	10.1%	9.3%	9.0%	8.3%	7.2%	6.8%	9.1%	9.7%	8.7%	7.8%

Note: HSMR data reflective of period Mar 21–Feb-22 based on a rolling monthly published position. SHMI data is based on a rolling 12 month period and reflective of period Jan 2021 to Dec 2021 published (May 2022).
Readmission data excludes CDU, AAA and all ambulatory areas where there are design pathways

What the information tells us

Mortality as measured by the summary hospital-level mortality indicator (SHMI) is as expected for the year February 2021 - January 2022. We are one of 96 trusts in this category. Our latest HSMR, for the 12 months from March 2021 to February 2022 shows our mortality to be lower than expected. Looking specifically at emergency admissions, mortality is lower than expected for those patients admitted during the week and as expected for those admitted at the weekend. SHMI and HSMR have taken differing approaches to managing the impact of Covid-19. Telstra (formerly recognised as Dr Foster), who produce the HSMR, include Covid-19 activity; whereas NHS Digital who are responsible for SHMI have excluded all Covid-19 activity.

The percentage of patients readmitted within 30 days following an Emergency admission was 7.76% in April 22. Performance shows special cause variation with an improving position.

Actions and Quality Improvement Projects

We continue to monitor and investigate mortality signals in discrete diagnostic and procedure groups from Telstra/Dr Foster through the Mortality Monitoring Group (MMG). The group are currently overseeing a number of ongoing investigations, namely ‘Acute Myocardial Infarction’, ‘Intracranial injury’ and ‘Genitourinary symptoms and other ill-defined conditions. Updates on each of these groupings are expected at the June MMG meeting.

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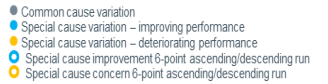
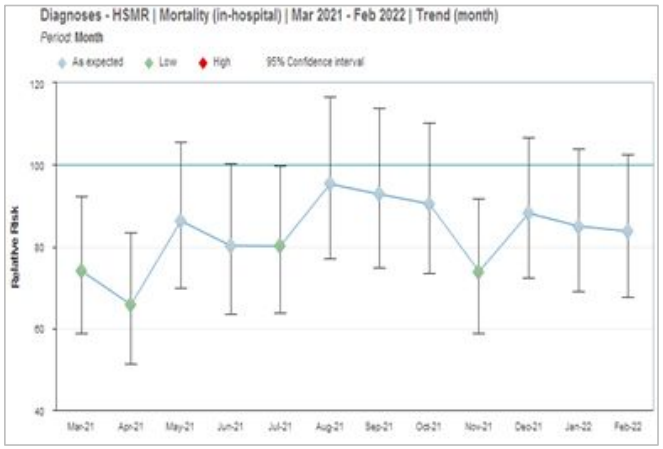
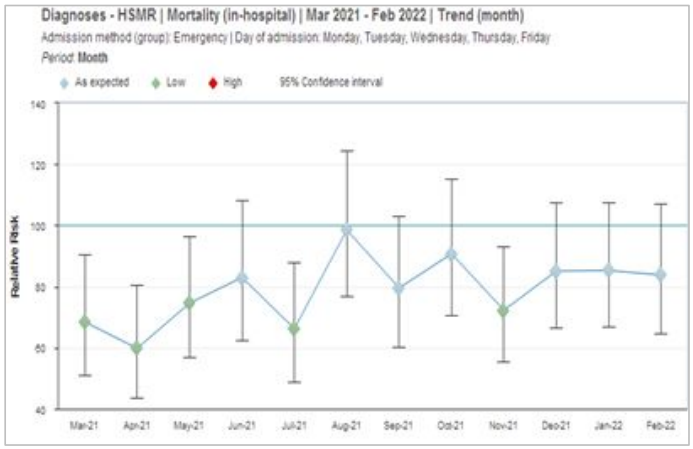
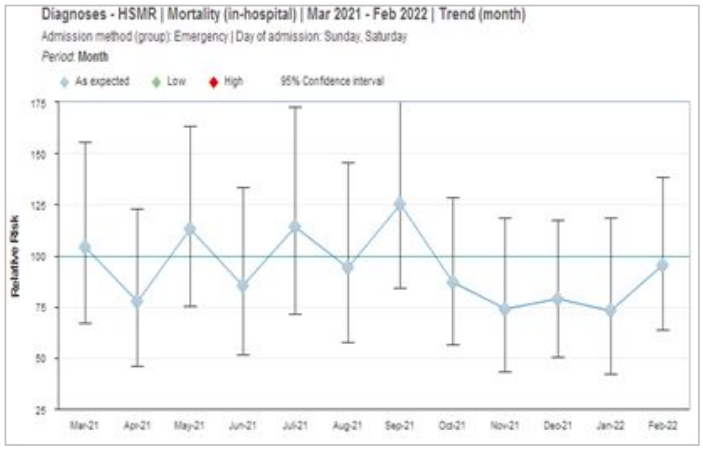
Mortality and Readmissions (Hospital Standardized Mortality Rate)

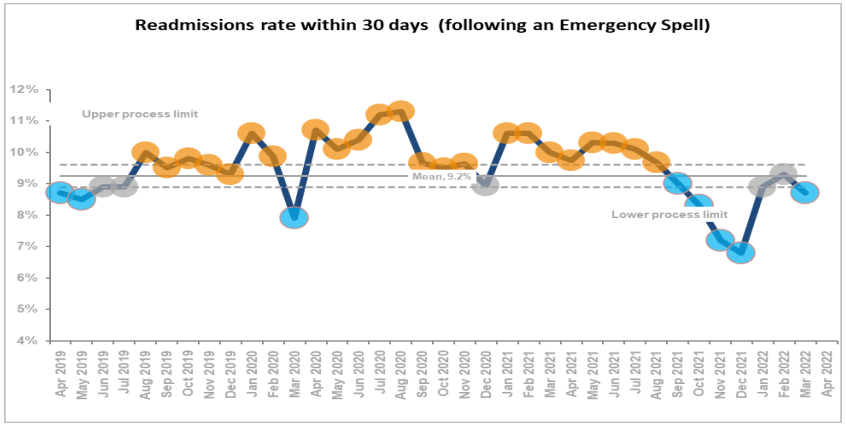








Inpatient Deaths (% of Discharges)



Our Patient Perspective

Friends & Family Survey

Indicator Description	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Emergency Department FFT - % positive responses	90%	83.4%	79.8%	81.6%	78.0%	73.6%	71.3%	75.5%	77.4%	80.2%	76.1%	72.0%	72.0%	68.3%
Inpatient FFT - % positive responses	95%	97.1%	97.5%	97.2%	98.4%	97.9%	98.9%	98.3%	96.0%	95.8%	98.2%	97.4%	98.4%	98.9%
Maternity FFT - Antenatal - % positive responses	90%	N/A	N/A	100.0%	50.0%	N/A	N/A	N/A	100.0%	N/A	N/A	N/A	N/A	50.0%
Maternity FFT - Delivery - % positive responses	90%	100.0%	90.0%	100.0%	N/A	100.0%	84.0%	86.8%	87.9%	85.0%	90.6%	92.5%	82.5%	79.2%
Maternity FFT - Postnatal Ward - % positive responses	90%	95.8%	91.9%	100.0%	0.0%	N/A	94.4%	100.0%	90.5%	100.0%	88.9%	100.0%	N/A	95.5%
Maternity FFT - Postnatal Community Care - % positive responses	90%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Community FFT - % positive responses	90%	87.5%	91.7%	100.0%	100.0%	92.9%	89.5%	94.1%	94.4%	100.0%	90.9%	96.0%	100.0%	92.9%
Outpatient FFT - % positive responses	90%	91.3%	90.7%	91.0%	89.8%	90.2%	90.3%	91.7%	91.9%	91.8%	92.5%	90.5%	91.1%	91.5%

What the information tells us

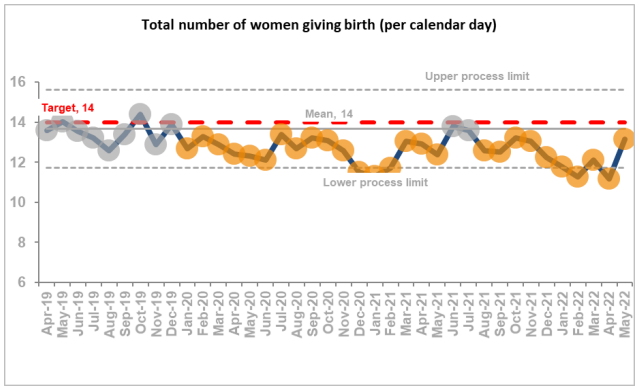
- Inpatient, Community, Maternity Postnatal Ward and Outpatient services achieved FFT targets where patients rated the services as "Good" or "Very Good".
- Performance for Emergency Department (ED) (68.3%), Maternity Antenatal (50%) and Maternity (Delivery) 79.2% were not met. ED, Community and Maternity (Delivery) shows special cause variation with a deteriorating position and Inpatient and Outpatient shows special cause variation with an improving position.

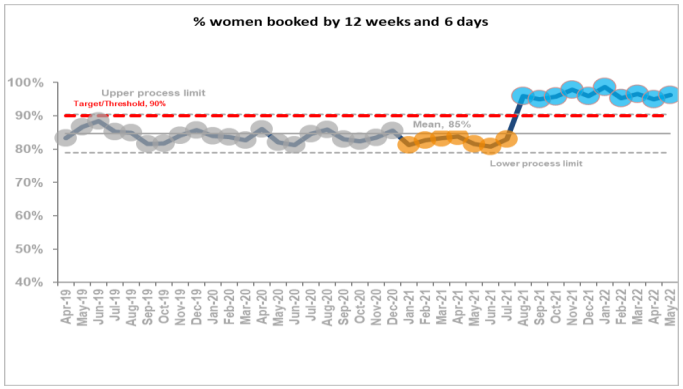
Actions and Quality Improvement Projects

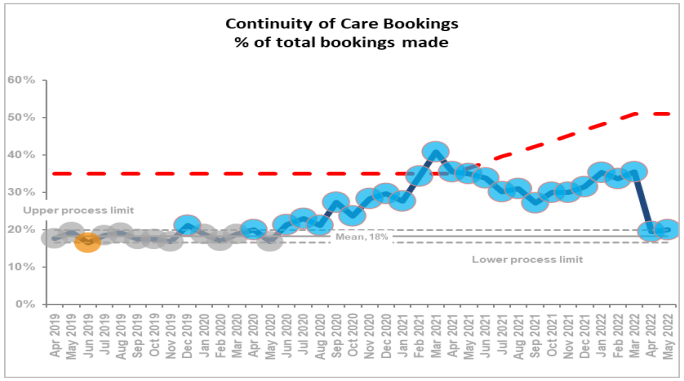
The FFT positive responses continue to be impacted by the current operational pressures in the Emergency Department and increased waiting times. In addition to these further themes have been identified in relation to nutrition of patients along with cleanliness and overcrowding of the department. Action is being taken to address nutritional needs of patients waiting in the department, alongside the Mitie and catering team.

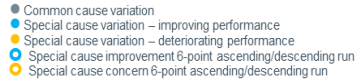
Maternity services continue to attempt to encourage women to participate in the FFT survey.

Maternity









What the information tells us

- May saw a increased birth rate with obstetric and medical complexity remaining high. Staffing remained challenging across the month with sickness and covid isolation, along with lead in times for recruitment start dates to fill band 5 and band 6 midwifery posts. Despite ongoing challenges the Labour Ward coordinator remained supernumerary for 100% of the time.
- Mitigation for staffing challenges included diverting birth centre and office based midwives to the Delivery Suite and other acute inpatient areas when required. This was required less frequently in May with our Birth Centre closed 18%, a slight improvement on May's position.
- Caesarean section rates were static at 28.7% in may which is where we would expect our rate to be and considered in the context of our other clinical outcome KPIs.
- There was a continued excellent performance in antenatal bookings with 98.25% of women referred being booked by 12 weeks and 6 days.

Actions and Quality Improvement Projects

- We recommenced working towards transforming our services in line with Continuity of Carer targets and have had continued input from the national Continuity of Care (CoC) midwifery team. We aim to further increase CoC here at SGH in a number of waves, with wave 1 due to be completed by September 2022. We are liaising with and reporting into the National team confirming our planned trajectory in line with Ockenden recommendations, although we continue to outline and confirm plans towards the safe implementation of wave1. This will support women within an area of deprivation and those identified as being at risk or BAME. The roll out and expansion will be done in line with staffing and vacancy/recruitment rates and plans.
- Digital Transformation across Maternity supported by the £1.8M funding to provide a single health records solution by the addition of a maternity module to our enterprise wide EPR (electronic patient record) is currently being implemented and continues with some pace. The digital platform will be purchased and much of the bid money has now been allocated with the project team working cohesively.
- The Maternity Telephone Helpline was successfully launched in late March 2022 after a slight delay due to staffing pressures. The Helpline enables direct access to the service for advice and information and will support consistent advice as well as clinically appropriate signposting. It has been co-produced with our Maternity Voice Partnership and the feedback to date has been very positive, from both women and staff. The Helpline has already been taking in excess of 1 call per 10 minutes with communication and advertising planned to ensure all women have the Helpline number.
- Following external confirmation of 100% compliance for the Ockenden immediate and essential requirements we received our site visit from the Regional teams on May 12 2022. The draft report following this visit has been received and returned with factual accuracies. The visit confirmed 100% compliance

Maternity

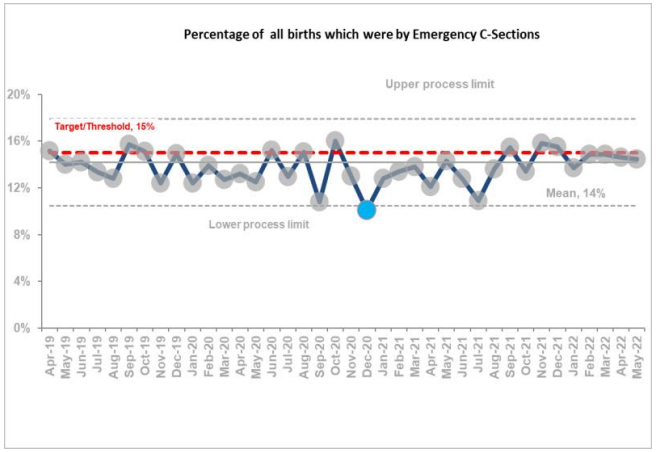
Maternity Dashboard

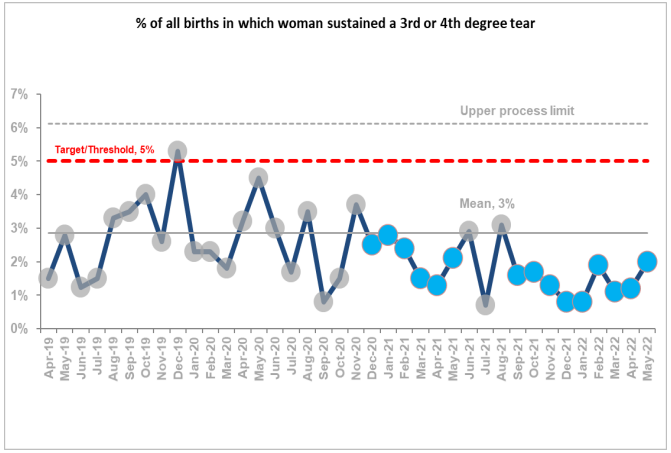
Definitions	Target	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Total number of women giving birth (per calendar day)	14 per day	12.4	13.8	13.6	12.6	12.5	13.2	13.1	12.3	11.8	11.3	12.1	11.2	13.2
Caesarean sections (Total Emergency and Elective by Delivery date)	<28%	27.6%	24.6%	24.7%	27.2%	28.3%	27.3%	31.4%	31.3%	27.1%	27.5%	33.3%	28.7%	28.7%
% deliveries with Emergency C Section (including no Labour)	<8%	3.9%	1.9%	3.6%	2.6%	4.5%	4.4%	5.4%	5.0%	3.0%	5.7%	3.7%	3.9%	4.2%
% Time Carmen Suite closed	0%	8.0%	18.3%	30.6%	74.2%	56.0%	21.0%	15.0%	27.4%	12.9%	44.6%	35.5%	22.0%	17.7%
% of all births in which woman sustained a 3rd or 4th degree tear	<5%	2.1%	2.9%	0.7%	3.1%	1.6%	1.7%	1.3%	0.8%	0.8%	1.9%	1.1%	1.2%	2.0%
% of all births where women had a Life Threatening Post Partum Haemorrhage >1.5 L	<4%	4.2%	2.4%	3.6%	2.3%	1.3%	2.9%	3.6%	2.4%	1.9%	2.5%	3.5%	3.3%	3.2%
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit		13	14	13	16	13	12	12	10	11	13	13	5	13
Number of term babies (37+ weeks), with unplanned admission to Neonatal Unit as a percentage of deliveries	6%	3.4%	3.4%	3.1%	4.1%	3.5%	2.9%	3.1%	2.6%	3.0%	4.1%	3.5%	1.5%	3.2%
Supernumerary Midwife in Labour Ward	>95%	98.4%	97.0%	88.7%	90.3%	90.0%	88.7%	98.3%	98.4%	98.4%	92.9%	95.2%	100.0%	100.0%
Babies born with Hypoxic Ischaemic Encephalopathy / (1000 babies)		0.8 (Qtr1)		2.4 (Qtr2)			0.8 (Qtr3)			3.8 (Qtr4)			Qtr1 End June 22	
Still Births per 1000 Births	<3	5.2	2.4	7.1	0.0	2.7	9.8	10.2	2.6	0.0	0.0	0.0	6.0	4.9
Neonatal Deaths (KPI 72) per 1000 Births	<3	0.0	0.0	0.0	2.6	0.0	0.0	0.0	13.2	2.7	9.5	0.0	3.0	2.5
Continuity of Care Bookings- % of total bookings made (Target increases monthly by 1.5% towards a 51% target in Mar 22)	43.7%	35.0%	33.8%	30.1%	30.6%	27.2%	30.0%	30.0%	31.4%	35.3%	33.7%	35.5%	19.5%	20.0%
Percentage of all births which were by Emergency C-Sections (KP25+26)	15%	14.3%	12.8%	10.9%	13.6%	15.5%	13.4%	15.8%	15.5%	13.7%	14.9%	14.9%	14.6%	14.5%
% women booked by 12 weeks and 6 days	90%	81.5%	80.8%	83.0%	96.0%	95.0%	95.8%	97.9%	95.9%	98.7%	95.3%	96.6%	94.9%	96.3%

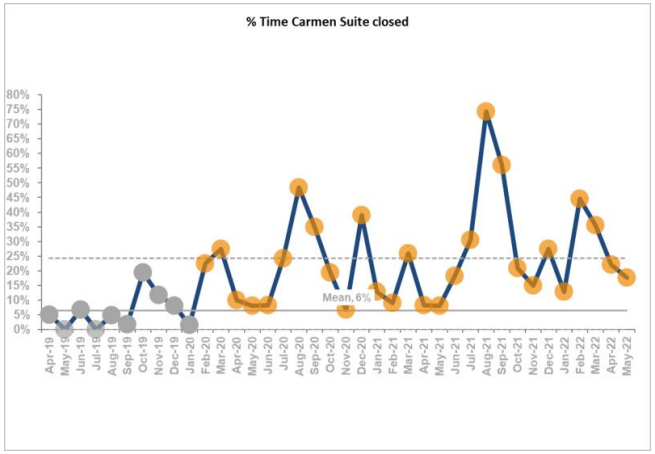
Our Patient Perspective

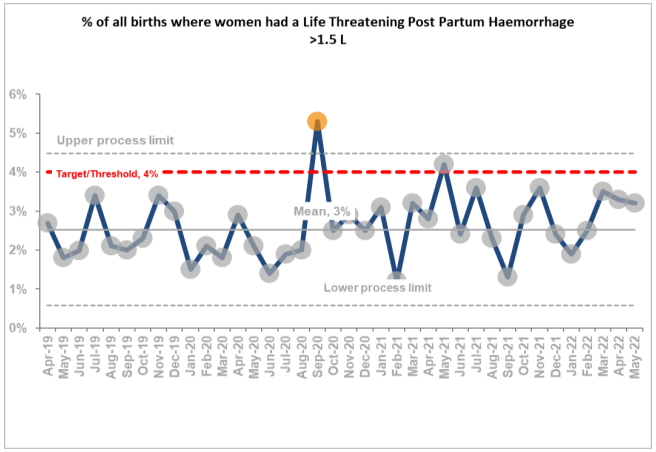
Maternity

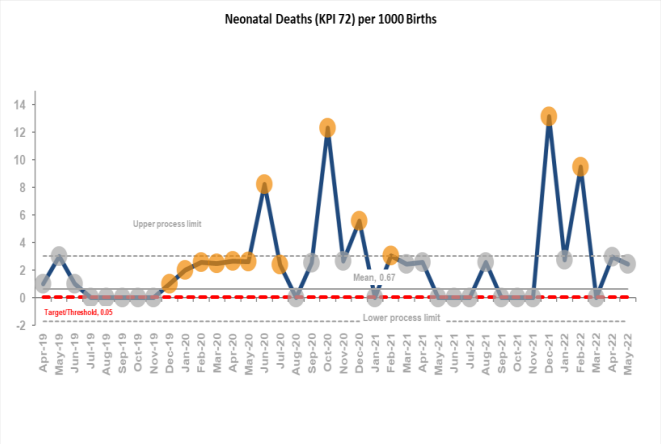
Common cause variation
Special cause variation – improving performance
Special cause variation – deteriorating performance
Special cause improvement 6-point ascending/descending run
Special cause concern 6-point ascending/descending run

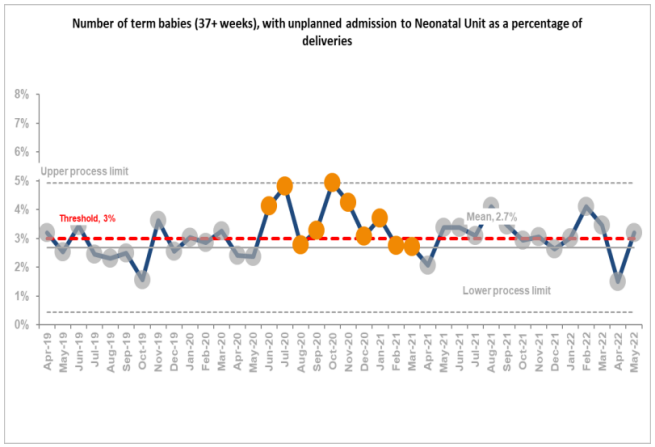




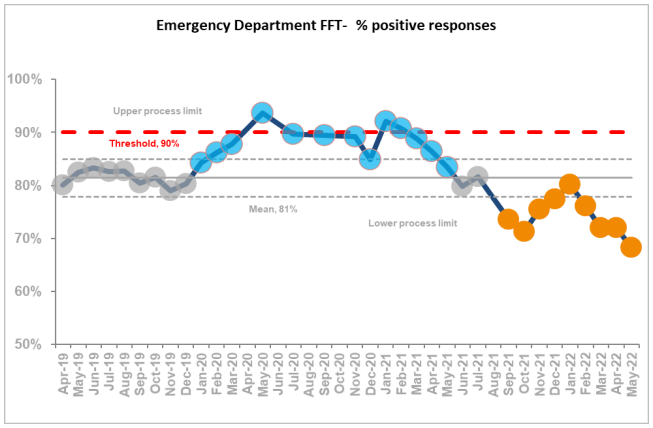


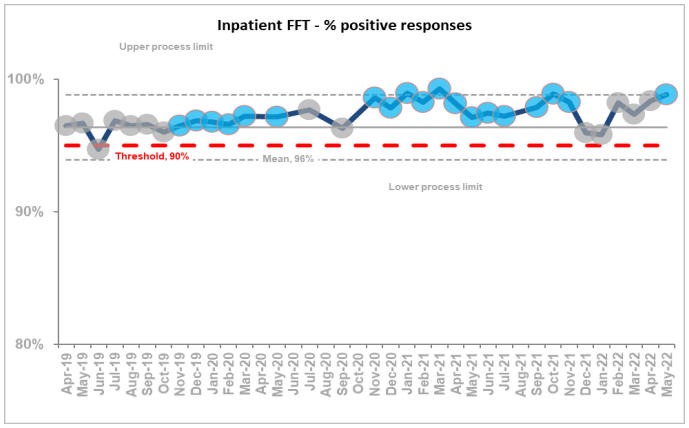


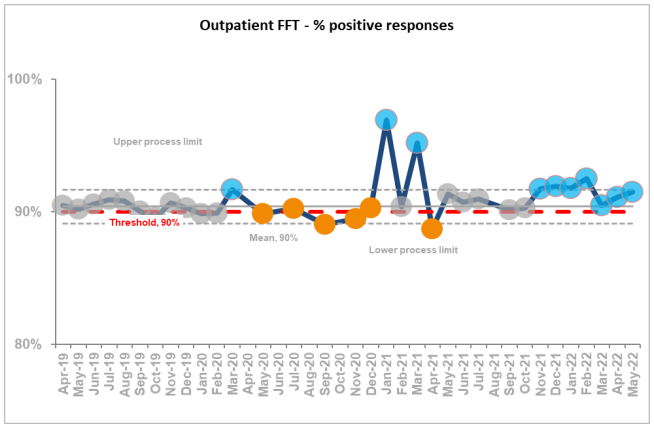


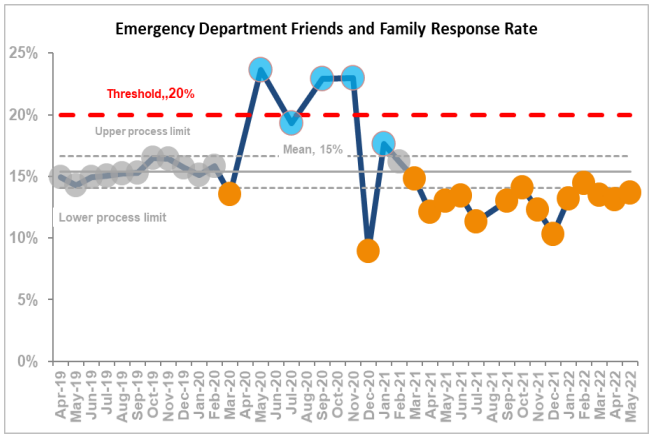


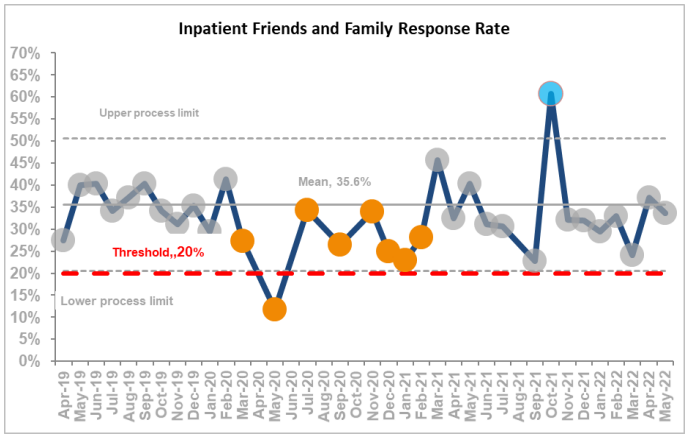
Friends and Family Test

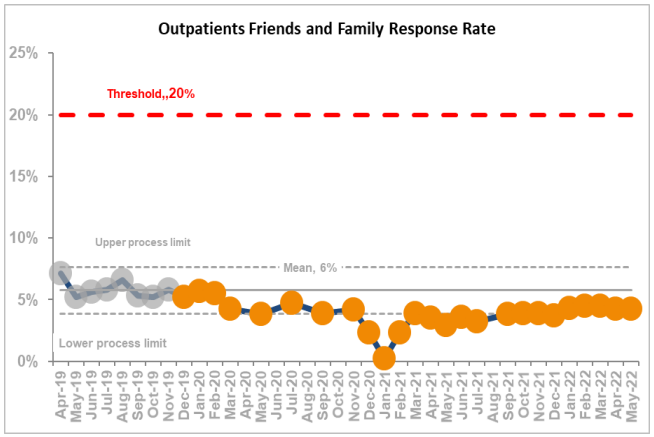








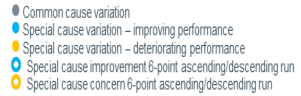


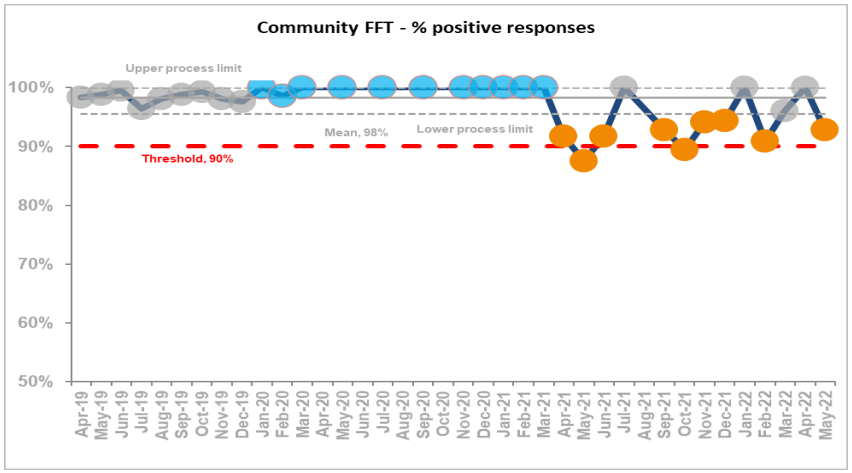


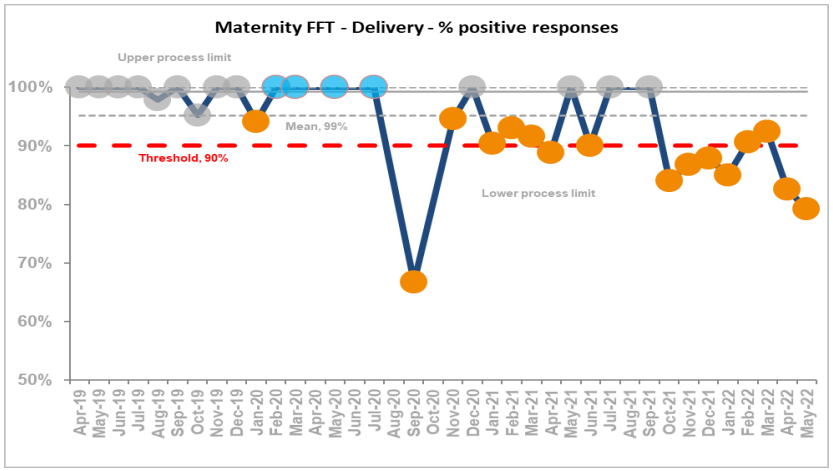
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

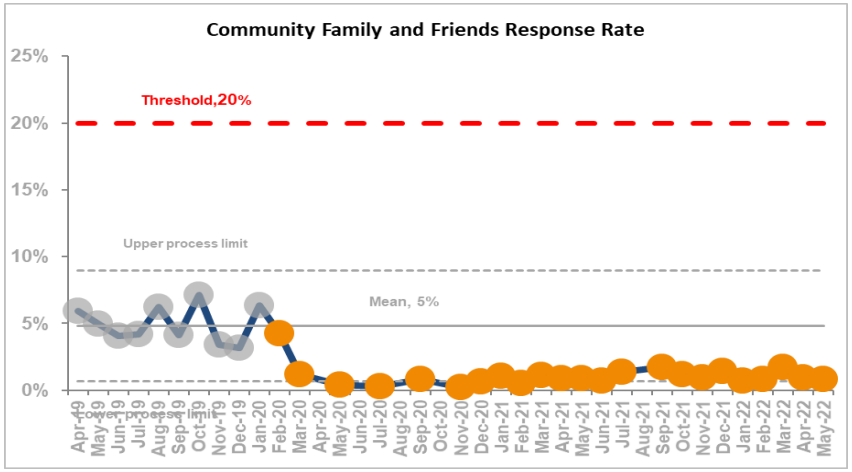
Our Patient Perspective

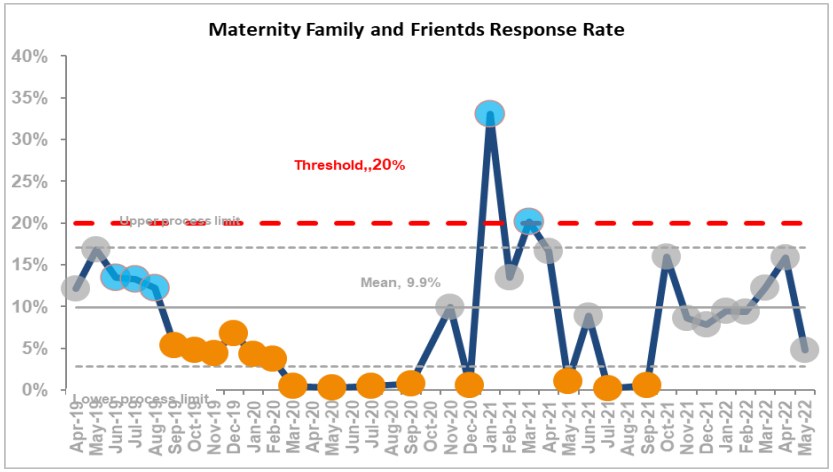
Friends and Family Test



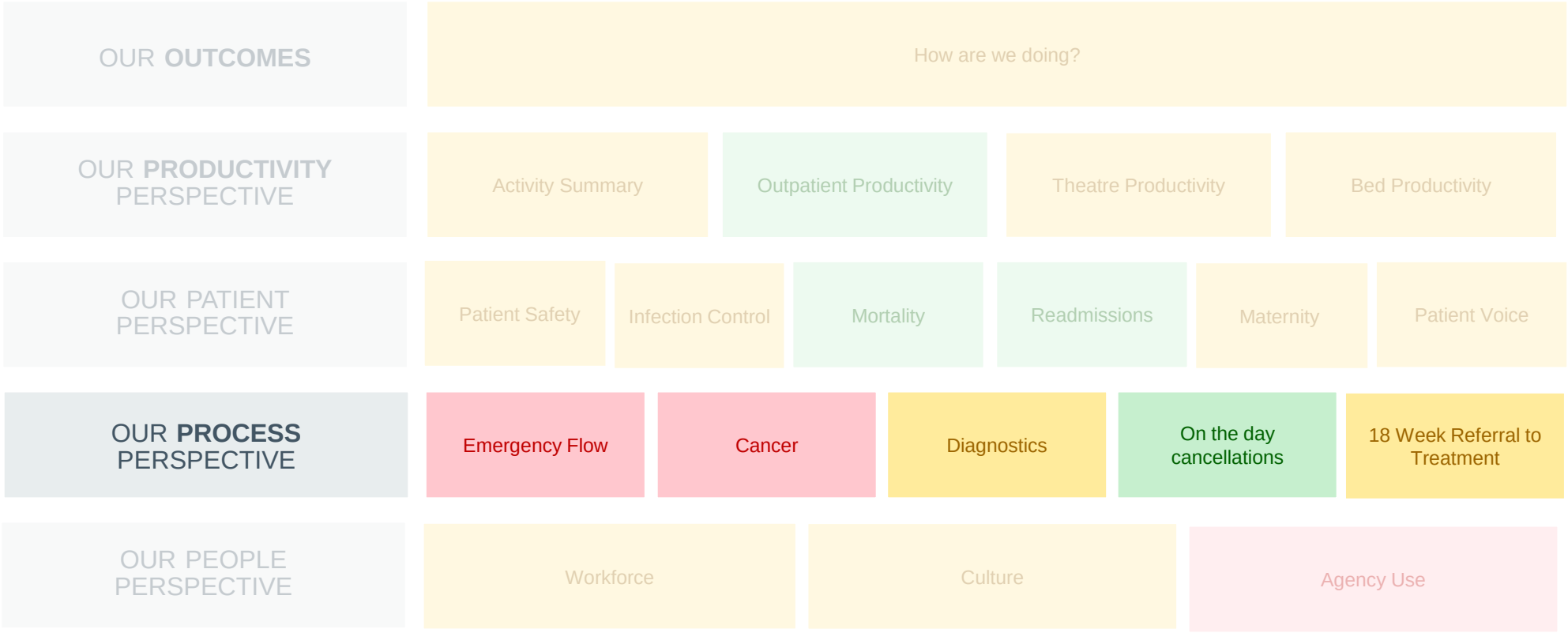




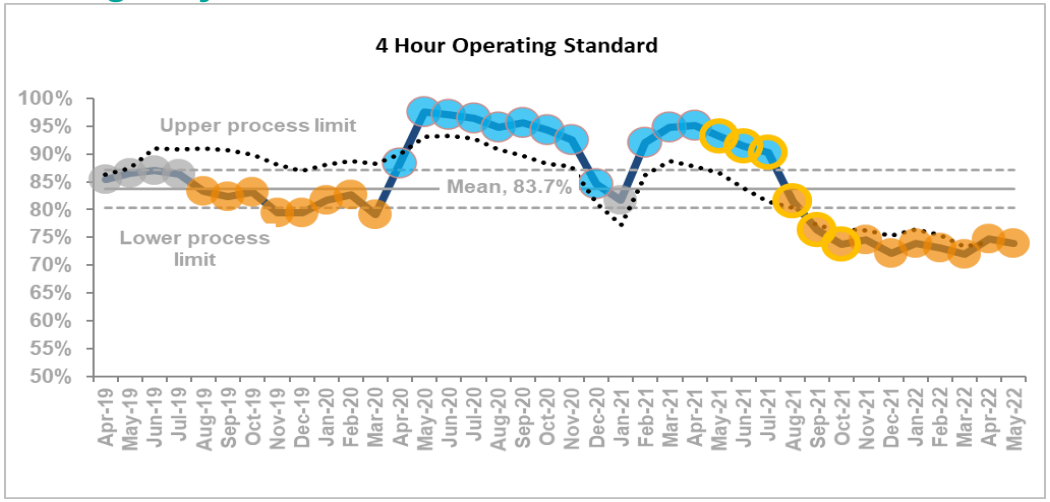


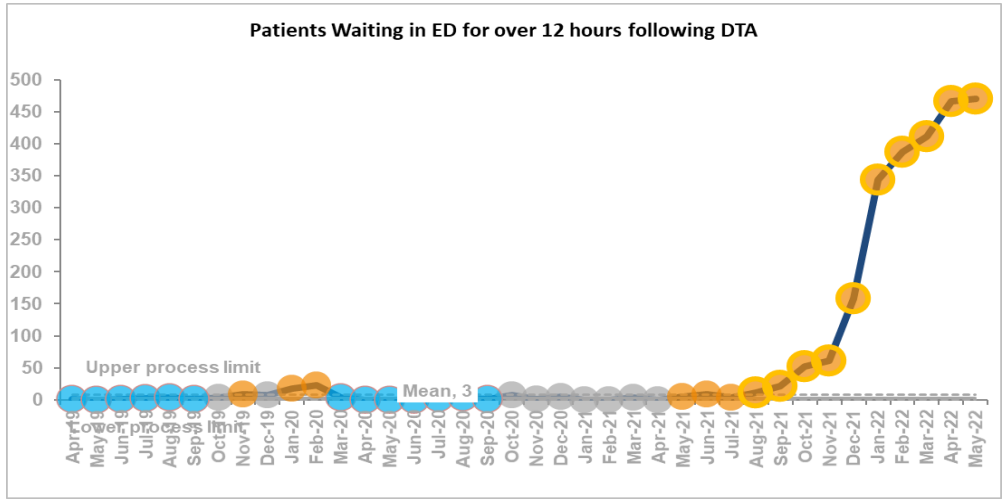


Balanced Scorecard Approach



Emergency Flow





What the information tells us

Performance against the Four Hour Operating Standard remains challenged with 73.9% of patients either discharged, admitted or transferred within four hours of their arrival across the month of May, this is comparable to the rest of London. Front end capacity remains constrained with a significant number of patients waiting in ED for over 12 hours following a decision to admit rising to 471 patients in May and a significant proportion of patients waiting for more than 60 minutes for ambulance handover. The average daily attendances to ED increased and although remining below the mean and baseline of 2019 the acuity of patients requiring treatment remains higher with 46% of patients presenting triaged as having a Manchester Triage Score of between 1 and 3. General and Acute bed occupancy continues to be higher than average, with AMU bed occupancy consistently above our target of 85%. High occupancy rates along with late discharges, staff absences and infection control measures continue to impact capacity and flow across the hospital.

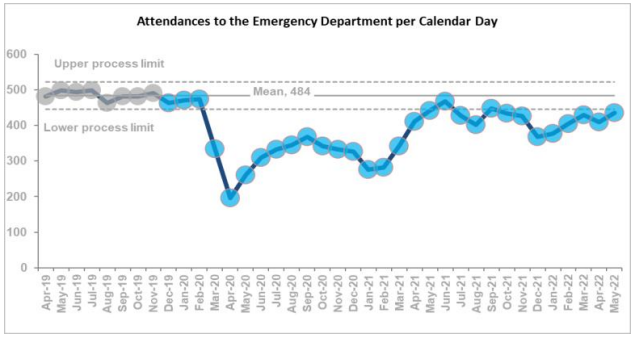
- Common Cause
- Special Cause Improvement
- Special Cause Concern
- Special cause concern 6-point ascending/descending run
- Special cause improvement 6-point ascending/descending run

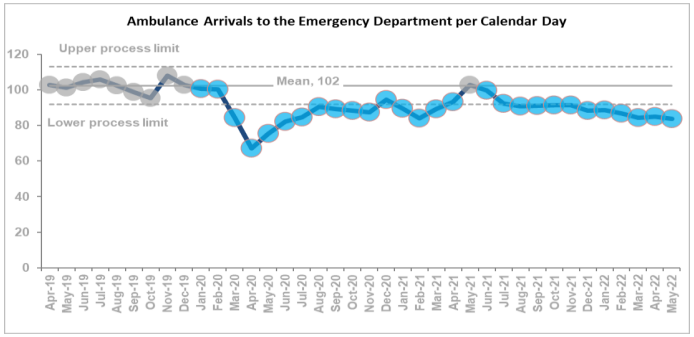
Actions and Quality Improvement Projects

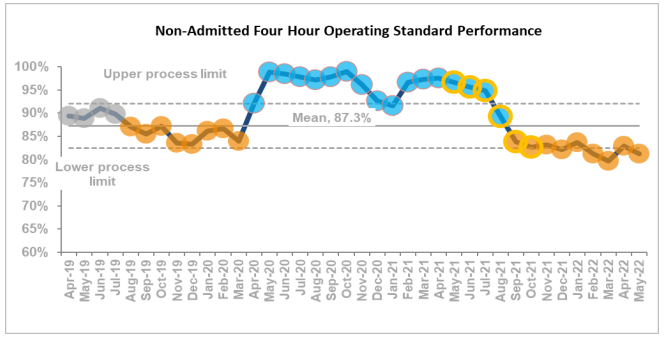
- The Trust is continuing to work seamlessly with system partners to reduce the number of patients waiting for social services
- ED Length of Stay Reviews as well as Daily matron reviews being undertaken
- 4 hour, 12 hour and 60 minute breaches are being added to Risk Register. Risks and safety issues are being reported on datix and discussed with COO / Exec daily
- Rounds of ED waiting room, to ensure safety of our patients waiting to be seen
- Maximising in/out space for doctors to see patients whilst the number of Decision-to-Admits (DTAs) remain high
- HALO (LAS team member) on site 2-3 times per week to assist with safety of LAS awaiting cubicle space.
- Inter Professional Standards meetings with Specialties to review existing guidelines and agreements regarding patient pathways and to deepen existing working relationships continue
- Gynaecology Same Day Emergency Care (SDEC) pathway launch, referring patients from ED suffering with Hyperemesis Gravidarum (extreme morning sickness).
- Flow Programme Departure Lounge Project is now supported by a matron with the aim to increase throughput to release beds earlier on in the day
- Stranded patient weekly reviews focussing on the most complex patients with extended LOS
- Registered General and Mental Health Nurse (RMN) bank pool continues to progress with a number of B4 and B5 members of staff now available to support the Emergency Floor

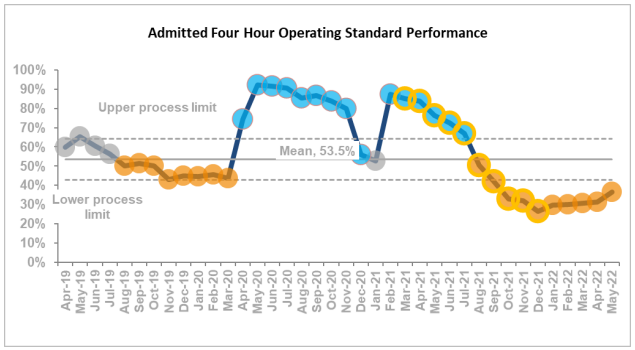
Our Process Perspective

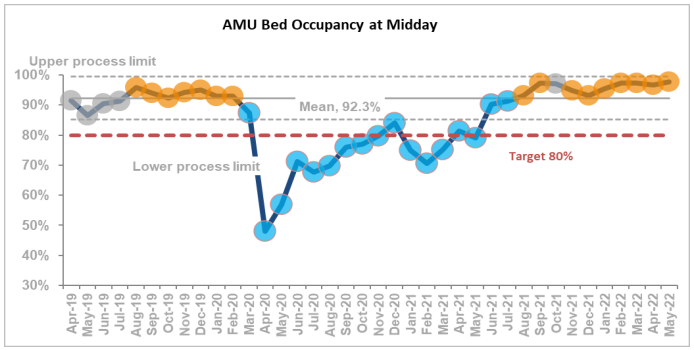
Emergency Flow

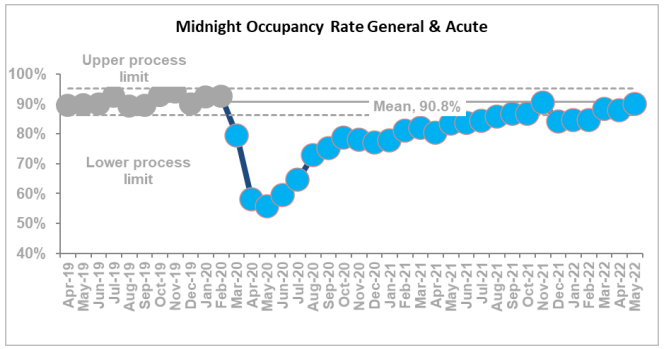


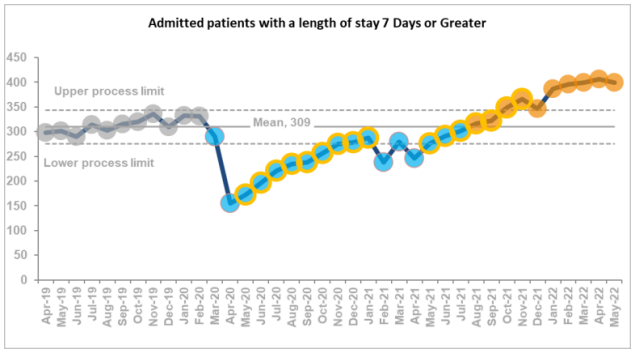


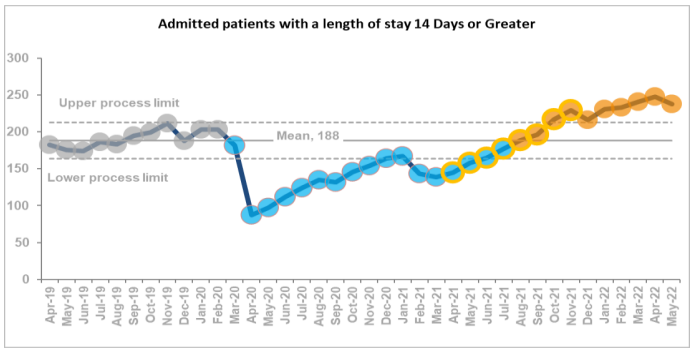


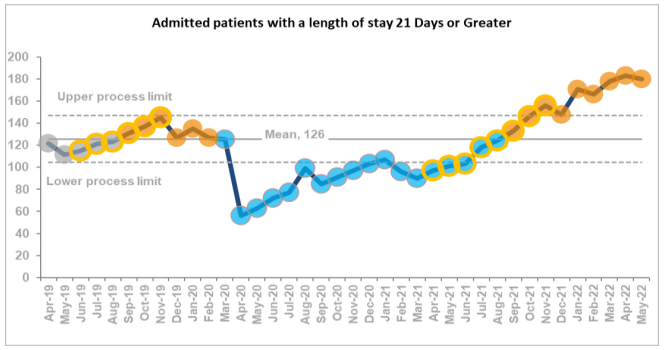






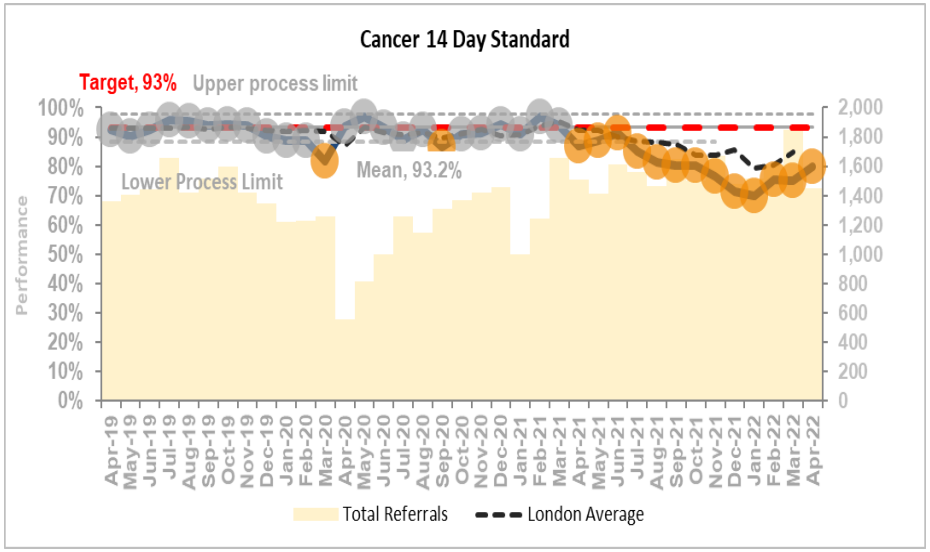


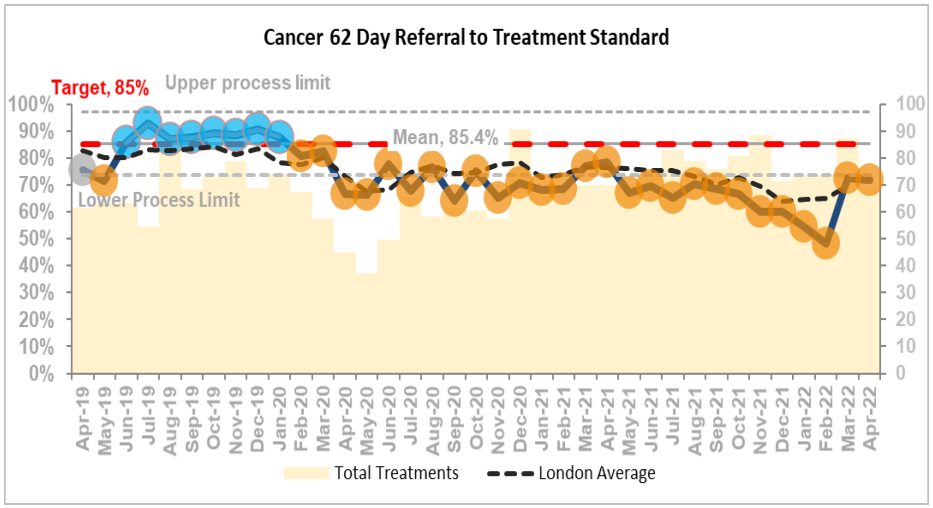




Our Process Perspective

Cancer





What the information tells us

Positive increases in performance were seen across the month of April and the Trust met three of the national cancer standards, Cancer 31 Day Diagnosis to Treatment, Cancer 31 Day Second or subsequent Treatment (Surgery), Cancer 31 Day Second or subsequent Treatment (Drug).

Performance against the 14-day standard continued to see steady improvement reporting 79.8% of patients seen within 14 days of referral compared to 75.2% in March, this remains in line with London performance. The total number of referrals eased in all tumour groups, particularly within Breast and Skin. A number of tumour groups moved to a non-compliant position in April notably within Gynae and Head & Neck, however Trust performance is off-set by improvement in Breast were performance increased by 42%.

Performance against the 31-day treatment standard in April was 96.4% meeting the target of 96% for the first time since September 2021 and moving to within the upper and lower control limits. Three tumour groups were below target although seeing an improved position; Breast (94.3%), Skin (85.7%), and Urology (94.4%).

In April there were 69 accountable treatments on the 62-day GP pathway, of which 49.5 patients received treatment within 62 days, 71.7% against a target of 85%, maintaining the improvement seen in March. Urology moved into a compliant position reporting 85.7%.

Actions and Quality Improvement Projects

The Cancer improvement Programme 2023/24 overseen by the trust cancer group will focus on:

- Achieving the cancer access standards trajectories
- Achieving Faster Diagnosis Standard
- Improving Multidisciplinary Team (MDT) working
- Expanding Rapid Diagnostic Programme
- Implementing a dedicated surgical cancer ward

TWR Performance

- The trust saw an improvement in the TWW to 79.8% mainly onset by improvements in breast.
- This was attributed to a increase in one stop WLIs and the deliverables of the breast recovery plan.

Faster Diagnosis Standard

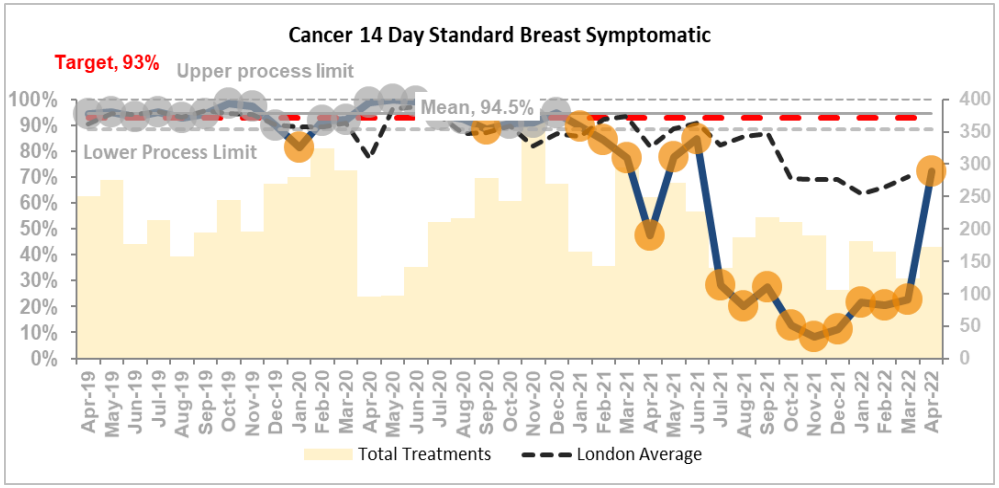
- The trust FDS performance in April 22 was 77.7% which is ahead of agreed trajectory and the national standard of 75%. (Details of the recovery plan is on slide 36).

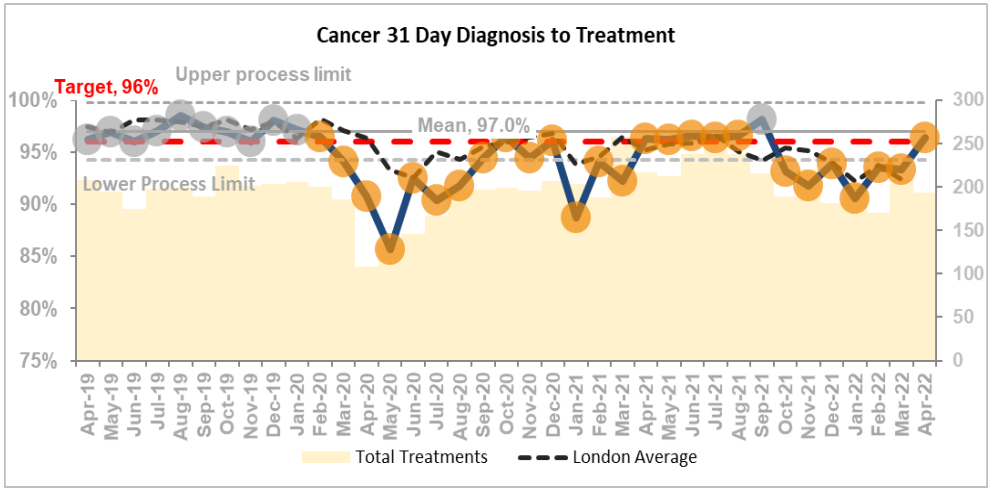
62-day Performance

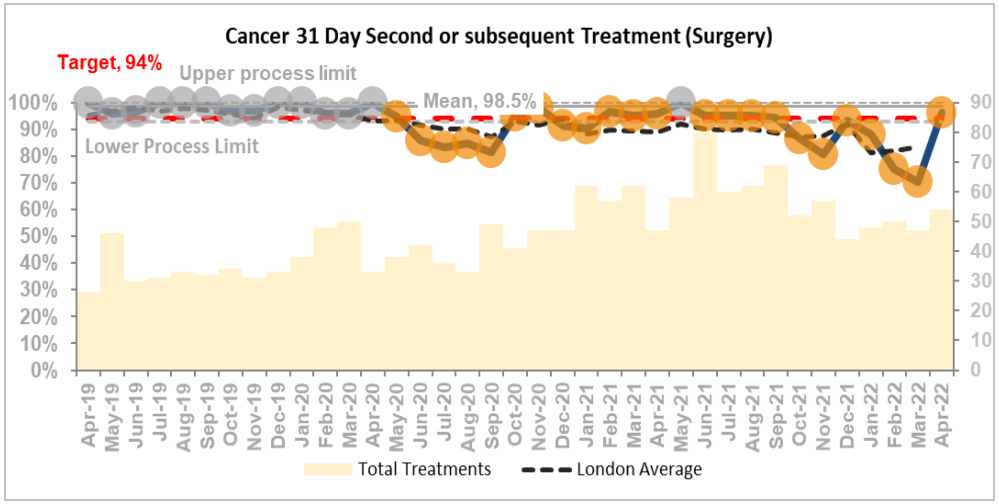
- The Trust 62 day position in April 22 was 71.7% ahead of the agreed trajectory of 70%.
- The main factors affecting this are; Patient choice and complex pathways, late inter trust transfers, pathology radiology capacity and tumour specific challenges in Urology, Breast, Lung, skin. The Programme of work will focus on:
    - The delivery of best practise timed pathways to facilitate earlier triage and increase straight to test
    - Achieving faster diagnosis (details in Slides 36)
    - MDT improvements from MDT to treatment by releasing radiology, pathology and MDT lead time
    - Pathology and radiology expansion and recovery plans

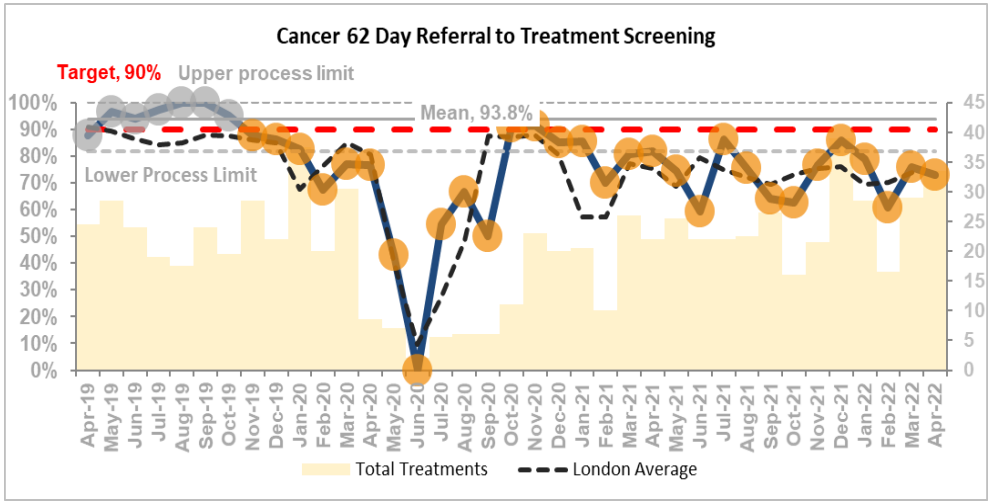
Our Process Perspective

Cancer



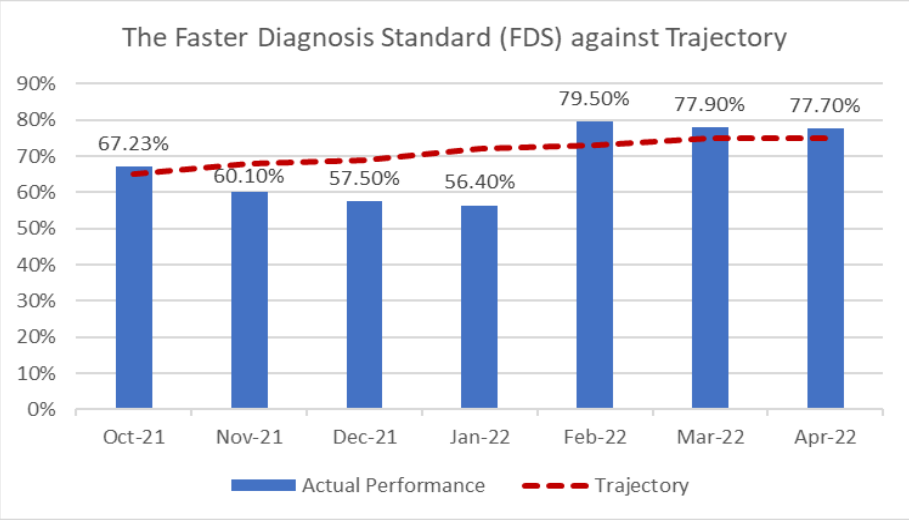


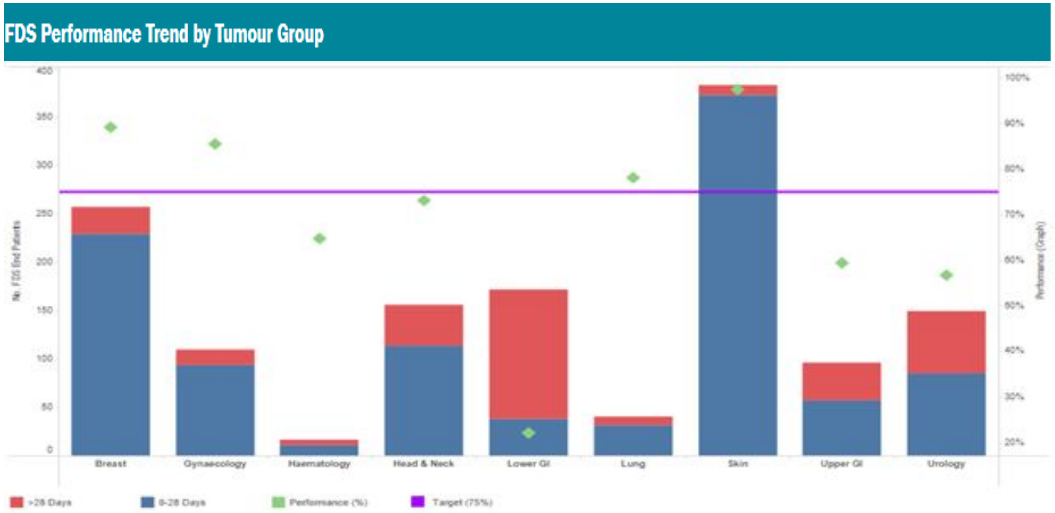




Our Process Perspective

Cancer – Faster Diagnosis Standard (FDS)





What the information tells us

The Faster Diagnosis Standard (FDS has recently been introduced to ensure patients who are referred for suspected cancer have a timely diagnosis, designed to speed up cancer diagnosis and improve patient experience.

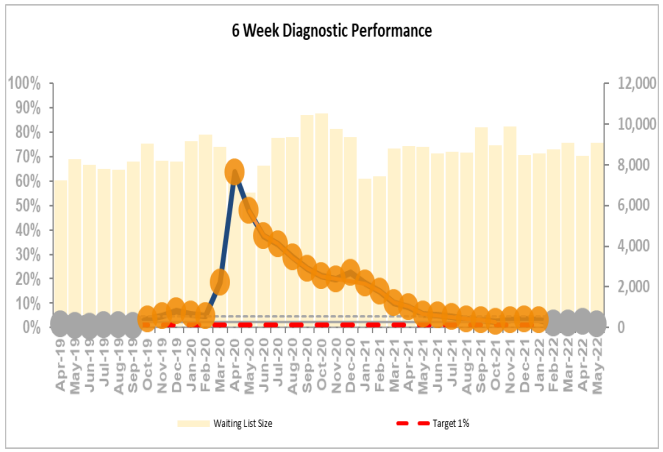
In April, the Trust continued to meet the 75% standard with 77.7% of patient's receiving a communication of diagnosis for cancer or a ruling out of cancer, or a decision to treat if made before a communication of diagnosis within 28 days following referral.

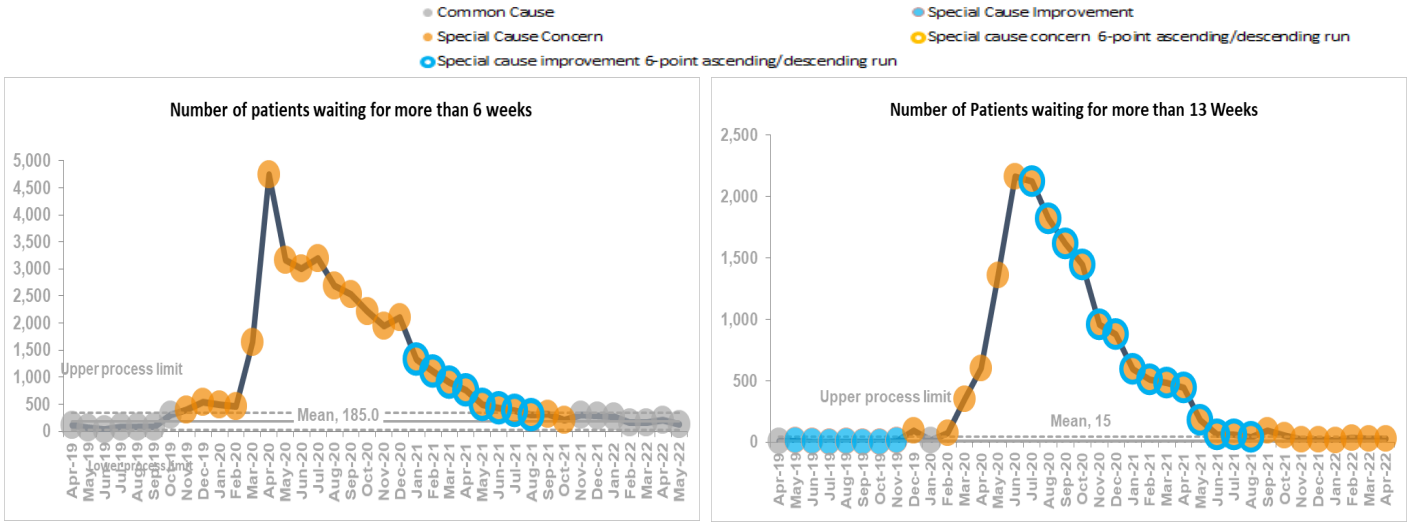
Actions and Quality Improvement Projects

- One of the main Objectives of **The Cancer improvement Programme 2023/24** is to deliver and sustain the faster diagnosis standard. The highlights of this plan include:
- The **GI services** action plan (with the lowest performance across the sector), which will be focused on access to timely diagnostics, complexity and patient navigation.
- The **Urology** actions plan is focused on bladder and penile challenges related to capacity and SWL pathways, The RMP cancer alliance is funding a sector wide improvement programme.
- The **Gynaecology** action plan will deliver increased access to one stop clinics and hysteroscopy capacity. The RMP transformation programme is in place to deliver best timed pathways and pilot the endometrial pathway.
- There are **live projects for 22/23** in collaboration with the alliance for Breast, H&N and Prostate.
- An **FDS champion** has been in post since April 22 to lead on FDS delivery as part of the cancer programme of work
- FDS **workshops and e-training module** will be developed.
- The **Radiology and Pathology** action plan is about access to expedited diagnostics and pathology reporting and will explore additional outsourcing, expansion of radiographers, focused recruitment plans, community diagnostics centers to support straight to test, alignment of order comms and pathology IT automation and establish PET CT.

Our Process Perspective

Diagnostics





What the information tells us

At the end of May, the Trust reported that 1.5% of diagnostic patients were waiting for more than six weeks on the diagnostic patient tracking list (133 patients), this is compared to the 2.4% reported in April. Recovery has largely been due to services re-providing ad-hoc capacity where possible. The overall waiting list size saw an increase of 6.3% compared to the previous month however continues to show a steady trend. Due to lost capacity as a result of the June bank holidays and annual leave the Trust is currently projecting a dip in performance at the end of June, however all services are committed to reducing the impact where possible and provide recovery plans where necessary.

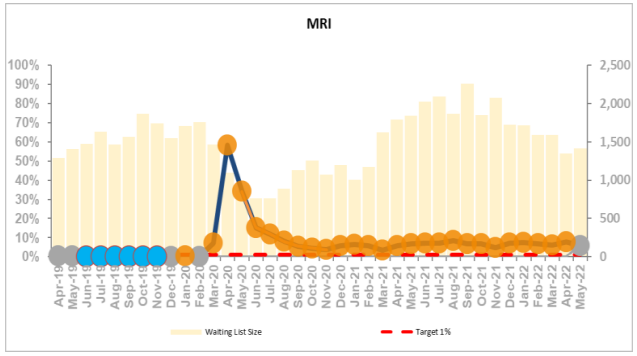
In May, Cardiac MRI did see an improved position with 16 less patients waiting over six weeks however, due to continued capacity challenges still hold the largest proportion of patients breaching six weeks, with 62% of the total breaches. Additional admin support has enabled the service to proactively manage attendances and rebook patients waiting the longest/highlighted at clinical review into vacated slots. Performance improvement in the month was also driven by Sleep Studies and Cystoscopy.

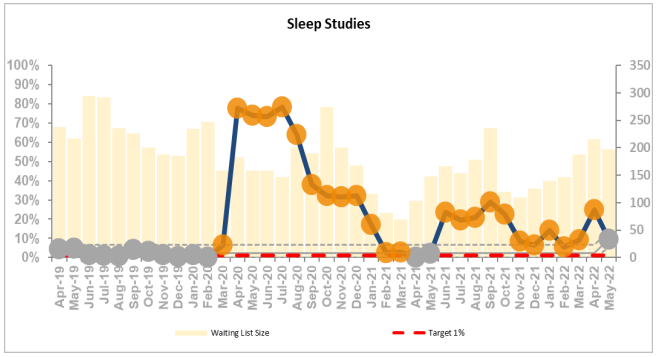
Actions and Quality Improvement Projects

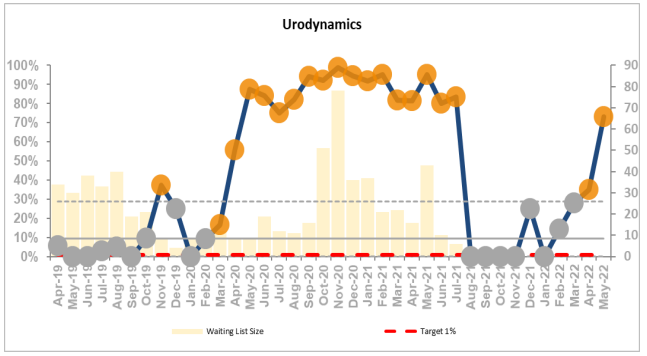
- Weekly performance meetings continue with particular focus on patients waiting for more than ten weeks. Divisional Director of Operations (DDO) support where areas are challenged.
- Cardiac MRI –Capacity challenges continue Additional MRI capacity with new MRI mobile unit from September. In the interim looking to provide Cardiac MRI capacity on existing capacity where possible to manage clinical risk. External capacity has been explored but not available.
- Sleep Studies – Following an increase in referrals and lost capacity, the service have improved performance by providing additional capacity through May, this is supported by the service now been fully established. Service to review demand to ascertain whether permanent increase in capacity is required.

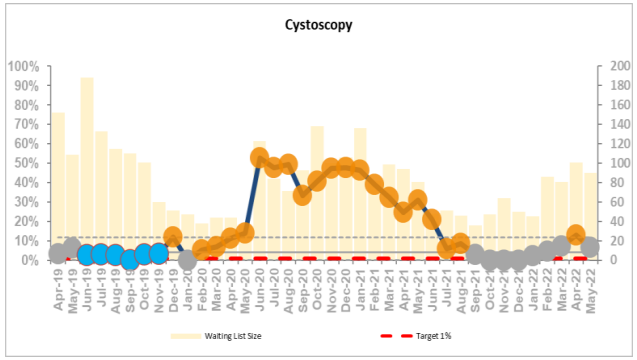
Our Process Perspective

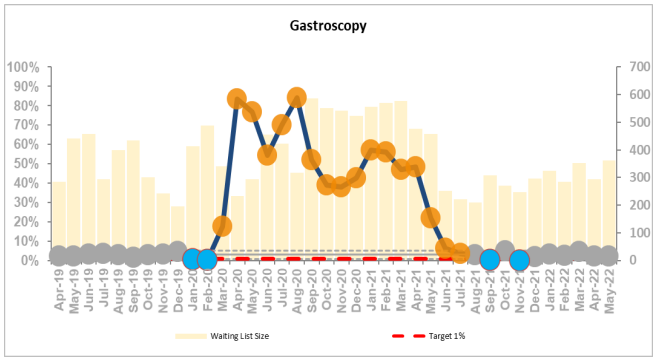
Diagnostics – Modalities Not Meeting 1% Target





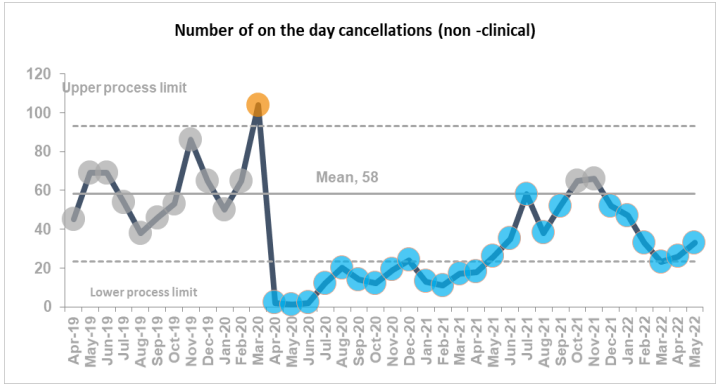


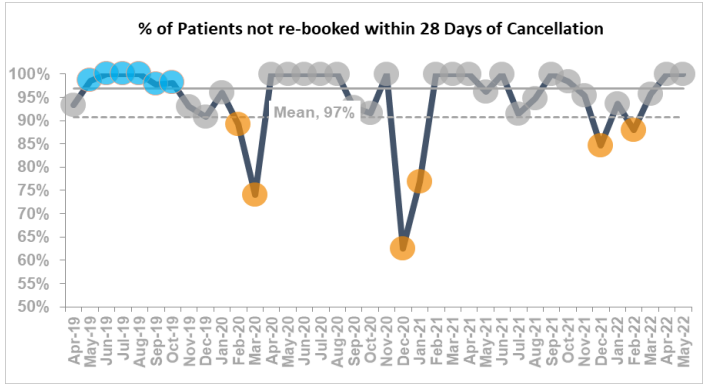


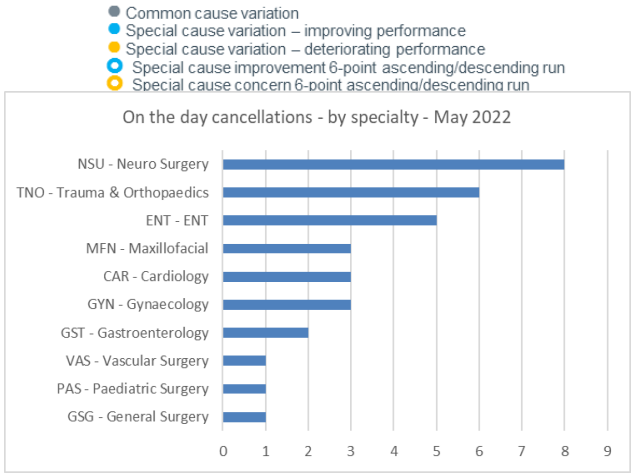


Our Process Perspective

On the Day Cancellations for Non Clinical Reasons(OTD)







What the information tells us

The number of on the day cancellations for non clinical reasons remains positively lower than the 2019 average. Avoiding cancellations continue to be driven by a clear focus on raising awareness of escalation processes along with concerted communication by operational and nursing leads. In total 33 patients were cancelled on the day with all patients due to breach 28 day's in May offered a date within target achieving 100%. Cancellations in the month particularly for Neuro Surgery and T&O were impacted by emergency demand.

In total for the month 33 patients were cancelled on the day of their procedure, broken down by the reasons below;

- Timing - Emergency case took priority– 10
- Timing - Complication - previous case/-s– 6
- Timing - List over booked – 4
- Staffing - Other– 4
- Bed - No Critical Care bed available– 1
- Bed – No Ward bed available– 1
- Staffing - Theatre Staff unavailable – 1
- Other - 6

Actions and Quality Improvement Projects

OTDC for non-clinical reasons increased in May by 7 patients (+26%) but this is in the context of Theatres delivering 27% more activity in May compared with April so from this perspective this does not represent a deterioration in performance. The main reasons for 'Non-clinical' OTDCs were actually caused by clinical drivers: 'Emergency case took priority'; 'Complications'.
The continued very low rates of PPNCOs (i.e. DNAs and OTDC) – currently standing at just 3%, which is 7% less than the pre-pandemic SGH rate of 10%, and 2% below the national benchmark target of 5% – has been driven by:

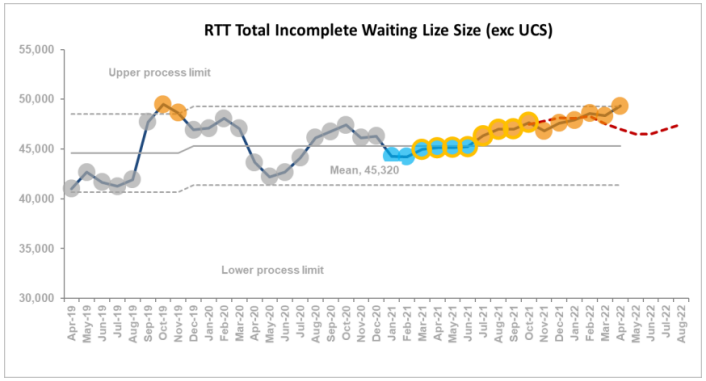
- Launch of a revamped OTD Cancellations for non-clinical reasons policy which focuses on raising awareness of the escalation process, to ensure that unilateral decisions were not being taken without consultation with all colleagues capable of avoiding a cancellation
- The relaunch has coincided with a concerted comms push by operational and nursing leadership to emphasise the importance of escalating in a timely fashion to help maximise the chances of avoiding non-clinical OTDCs.

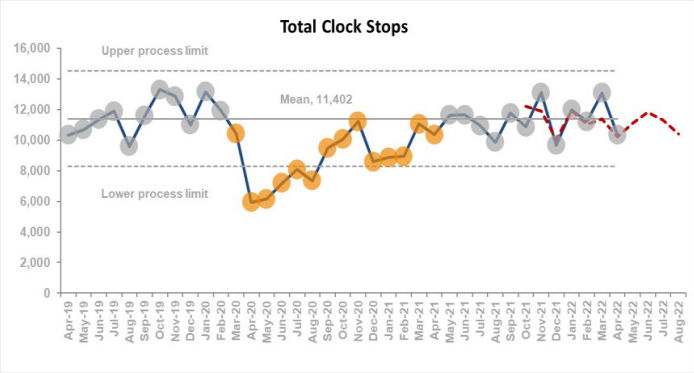
A further intervention was launched in January to open up a 'Yellow' SDL Discharge pathway from SJW to DSU to improve flow in SJW Recovery, maximise SDLs and minimise failed SDLs. This SOP was then updated in April to include the discharge of 'Green' pathway patients and re-launched to ensure that all opportunities to transfer patients are taken:

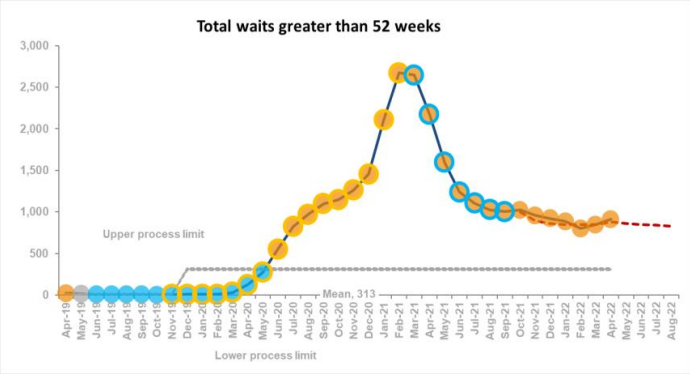
- Cancellations due to bed availability have fallen substantially.
- This is partly attributable to the new 'Yellow' SDL Discharge pathway.

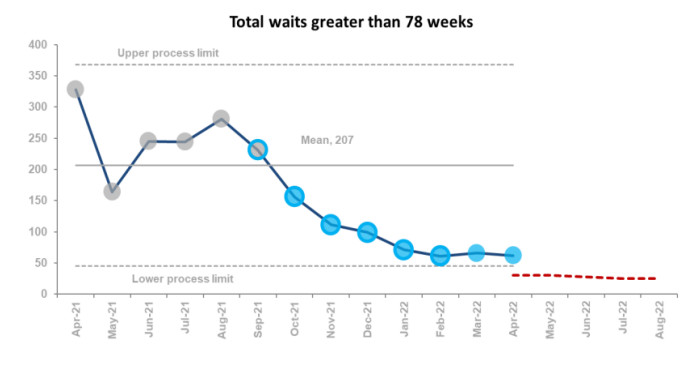
New processes are also being introduced in POA to improve the timely prioritisation of Urgent patients, to further reduce the risk of cancellation due to POA issues (although this reason was not listed as a cause for OTDC in either of the last two months).

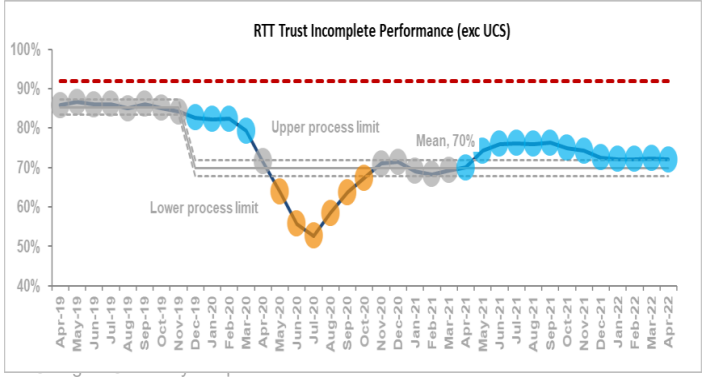
Referral to Treatment — April 2022











Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in April was 459, compared to 324 in March.

- Common Cause
- Special Cause Improvement
- Special Cause Concern
- Special cause concern 6-point ascending/descending run
- Special cause improvement 6-point ascending/descending run
- Trajectory

What the information tells us

At the end of April there were 49,329 patients waiting for treatment on the RTT PTL, seeing an increase of 2% compared to March, seeing an increase in both non-admitted and admitted pathways. The volume of clock stops also fell, however remains within the upper and lower control limits.

The Trust reported an increase in the number of patients waiting for more than 52 weeks reporting 911 patients compared to 846 patients at the end of March. Increases primarily seen within ENT on the non-admitted pathway and Cardiology and Plastics on the admitted pathway.

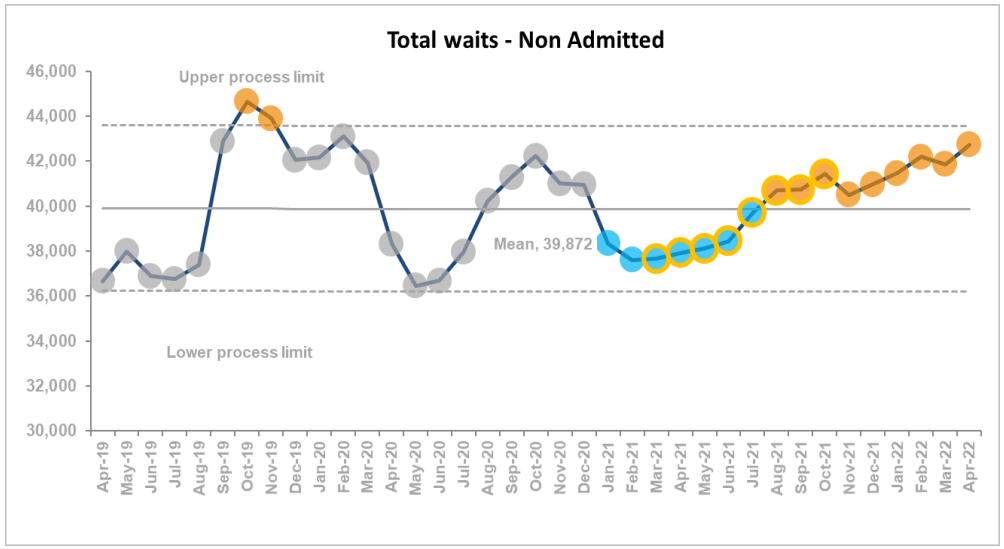
Actions and Quality Improvement Projects

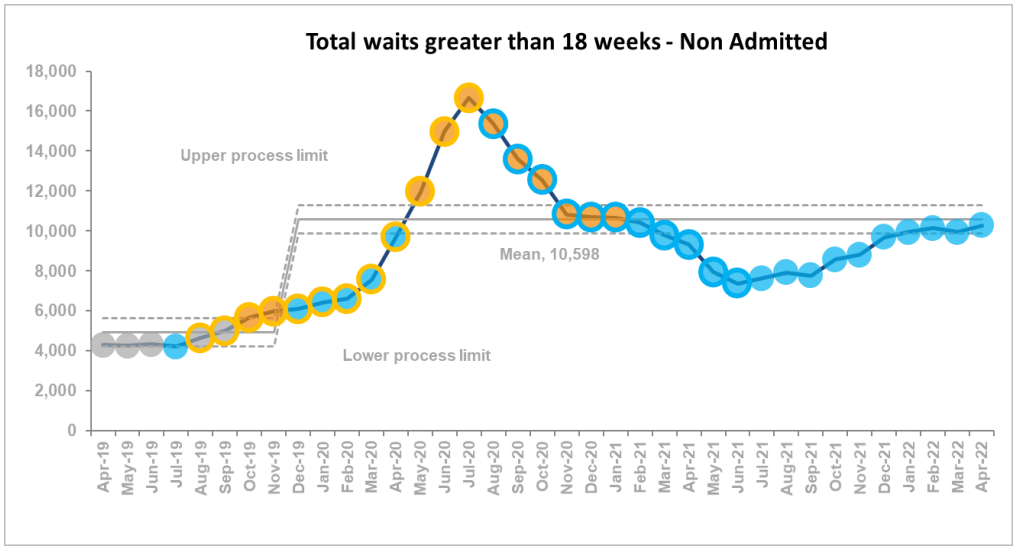
- April was a challenging month for activity – the reduction in working days impacted on the number of clock stops and removals. In addition, the average number of clock stops per working day was not sufficient to offset a continued increase in the average daily number of referrals. Work continues with the network to redirect patients at the referral stage which is key to improving equity of access to timely healthcare across SW London.
- General Surgery and ENT text message pilot complete. Outline business case to be submitted to continue with success of project and expand scope.
- Scoping of Palantir project to improve theatre efficiency and maximise productivity.
- All services will reforecast 52 week breach position to understand the ongoing level of risk. Most significant challenges and growth in ENT, Plastics and Cardiology.

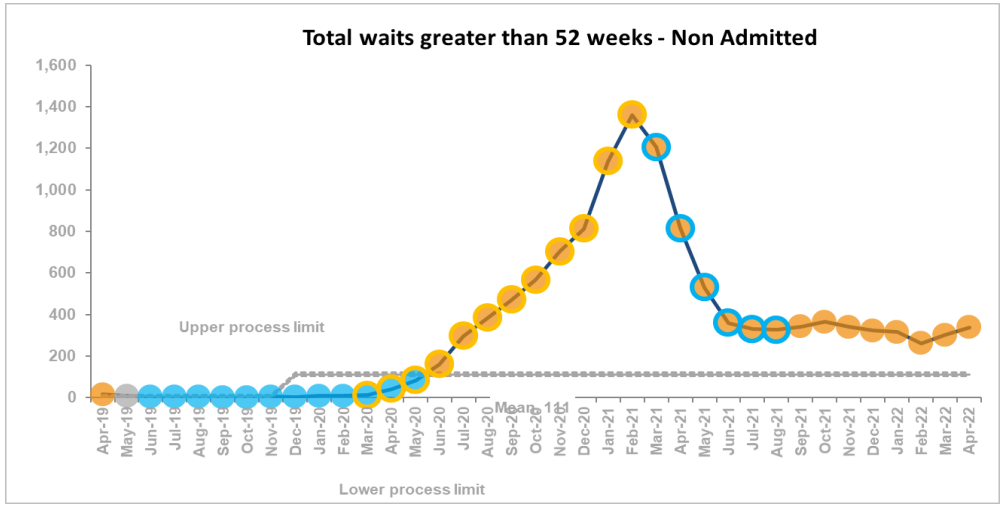
Our Process Perspective

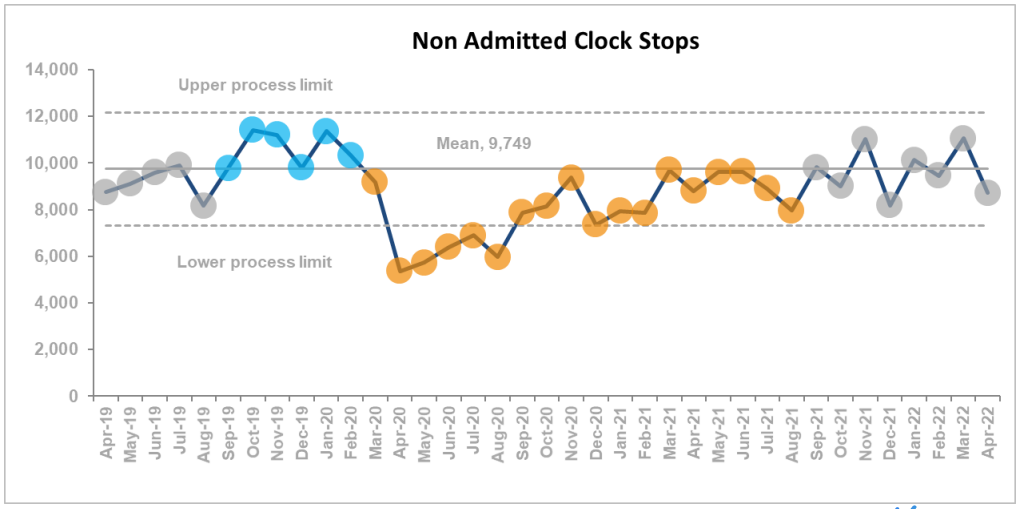
Outstanding care every time

Referral to Treatment Non-Admitted Pathway — April 2022



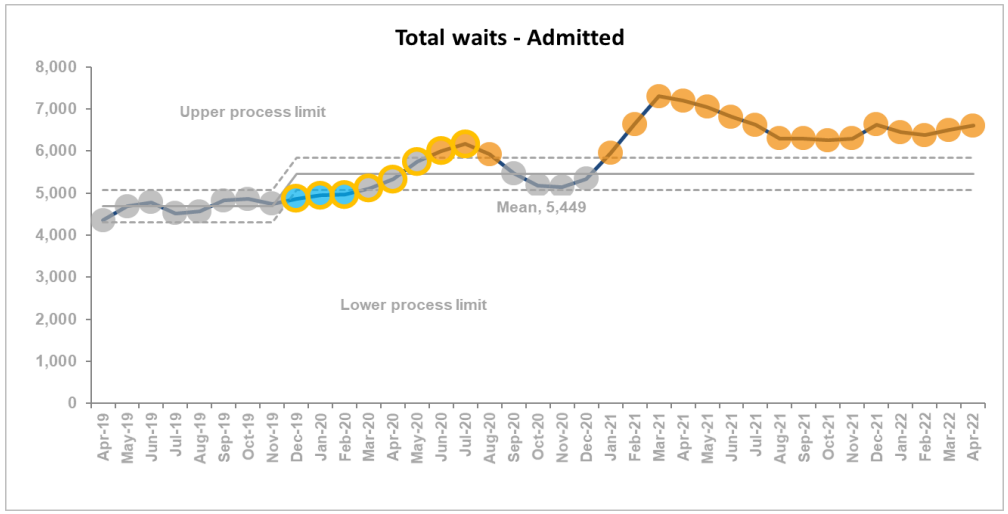


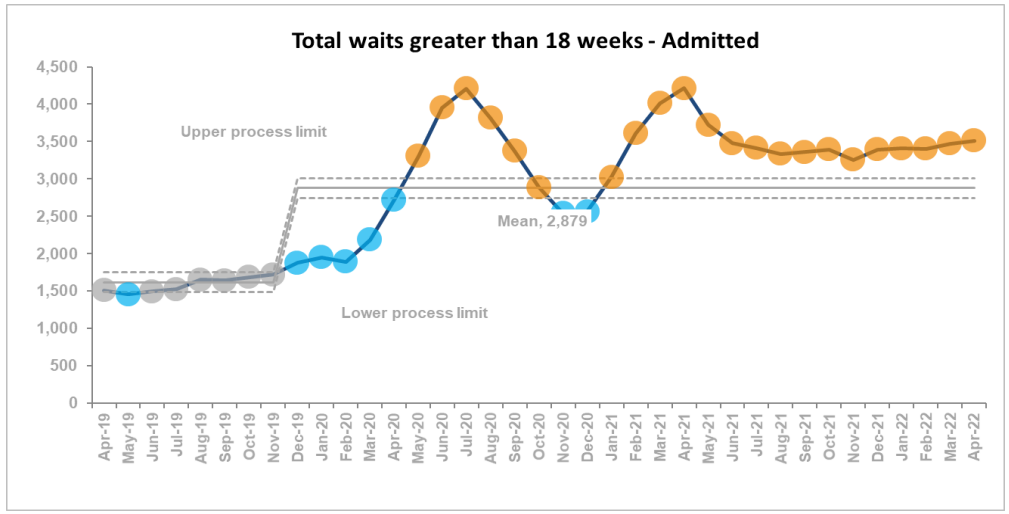


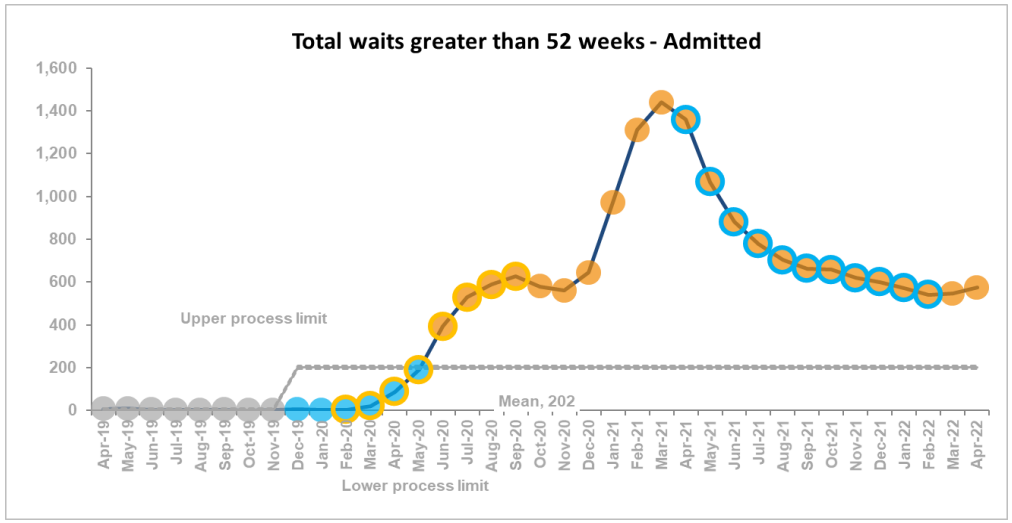


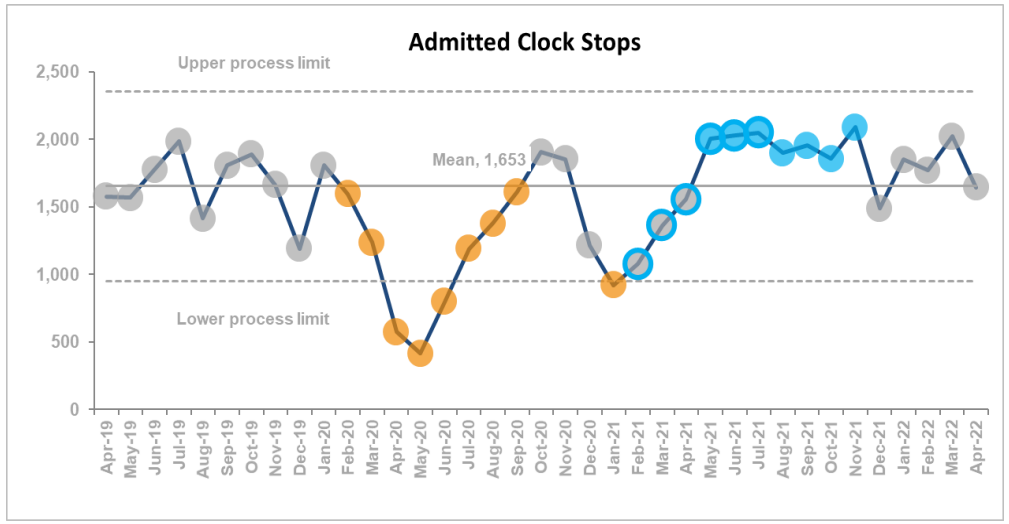
Our Process Perspective

Referral to Treatment Admitted Pathway — April 2022



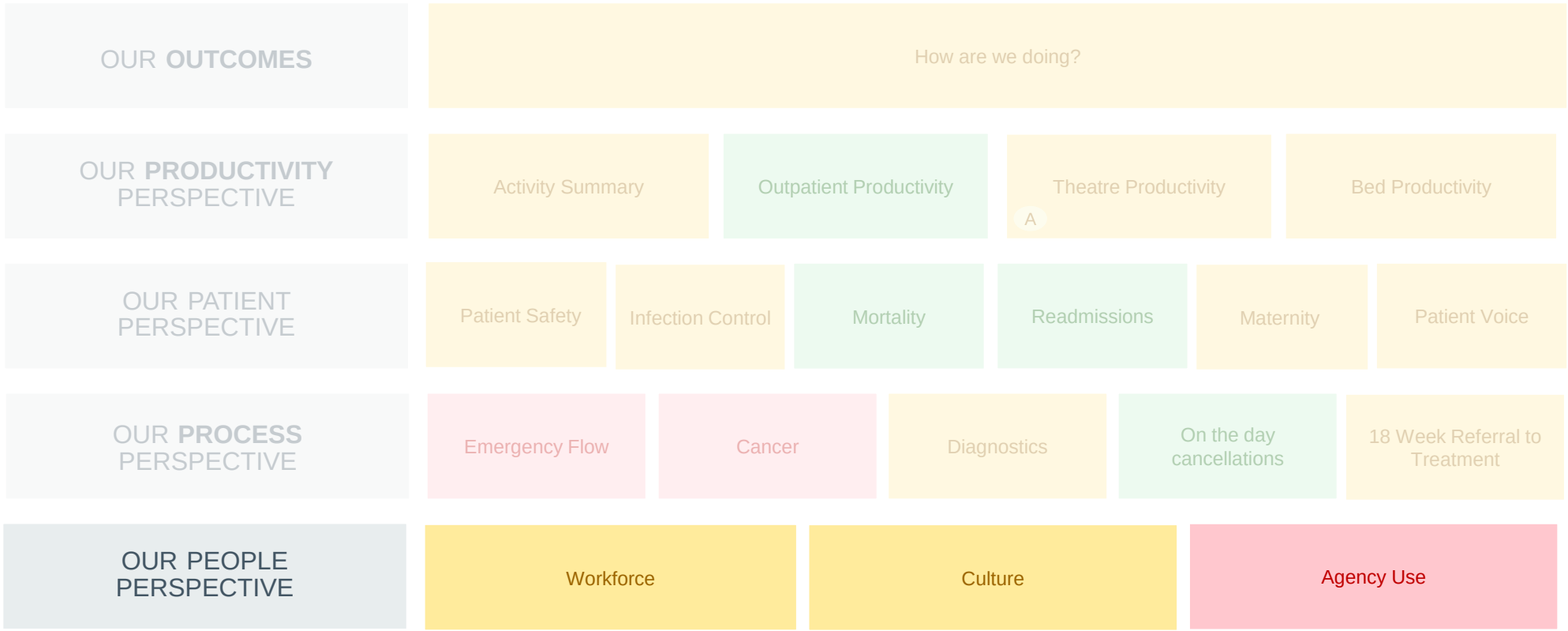






Our Process Perspective

Balanced Scorecard Approach



Workforce

Metric	Benchmark Average	Performance 12 months ago	Performance 3 months ago Feb-22	Current Performance May-22	Target	Distance to target	Current RAG Rating
Sickness	4.0%	3.6%	4.4%	3.95%	3.2%	-0.75%	✖
Vacancy	10.8%	9.2%	10.2%	9.4%	10.0%	+0.6%	✓
Turnover		14.6%	16.8%	17.1%	13.0%	-4.1%	!
Medical Appraisal		76.8%	76.7%	81.92%	90.0%	-8.08%	!
Non-Medical Appraisal	72.0%	76.5%	74.9%	71.3%	90.0%	-18.7%	!
MAST	85.7%	90.2%	88.2%	89.4%	85.0%	+4.4%	✓
Stability		87.7%	85.2%	79.1%	85.0%	-5.9%	!

What the information tells us

- The Trust's sickness rate was 3.95%, the lowest seen since August 2021.
- Vacancy Rate this month was 9.4%, which is below the threshold of 10%.
- Trust turnover rate in May was 17.1% and is adverse to the target of 13%.
- Medical appraisal rates and non-medical appraisal rates was non-compliant against the 90% target. Showing 81.92% and 71.3% respectively.
- Mandatory and Statutory Training (MAST) was 88.3% in April and increased to 89.4% in May.
- Stability performance fell for the second month running to 79.1% against a target of 85%.

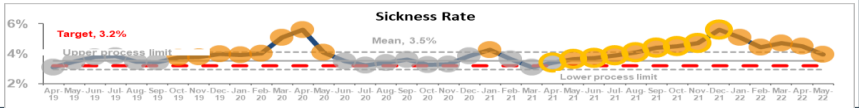
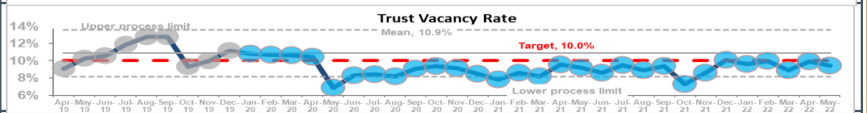
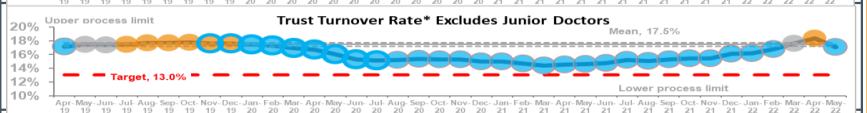
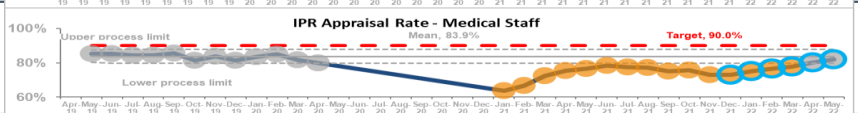
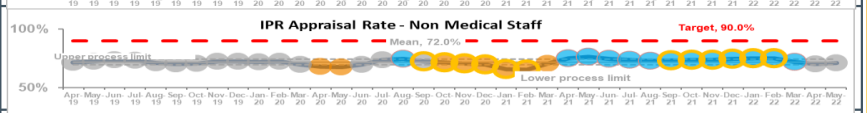
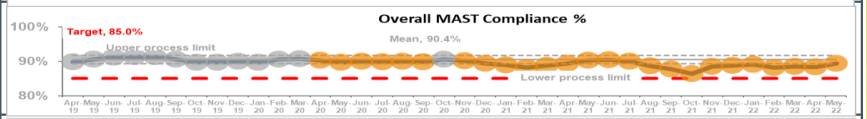
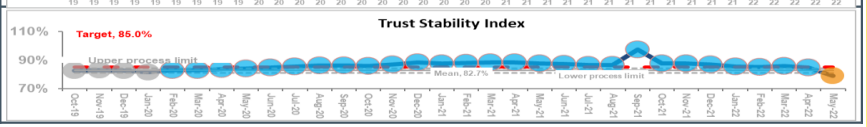
* Benchmark info is taken from Guy's & St Thomas', King's, Lewisham & Greenwich, Imperial, and UCLH.
* Turnover benchmarking isn't available as different Trusts calculate turnover in different ways

Actions and Quality Improvement Project

- **Sickness**- For both long and short term sickness, Human Resources continues to support managers to make timely Occupation Health referrals to establish support for staff on long term sick leave to facilitate their return to work including due consideration for reasonable adjustment. For those on short term sickness, HR continues to work with management to better utilise the return to work meetings and an engagement too to identify support for staff to enable them to improve the level of attendance. For stress related illness Launching a range of activities to support staff recovery and wellbeing as a part of the Big 5 campaign. Working with Staff Support on developing a toolkit to support staff who are off sick and/or returning to work after sickness absence.
- **Turnover-** Work is being undertaken including reviewing the recruitment process from end to end and dovetailing this with retention plans as data evidences that staff leave the trust within the first 2 years or less.
- **Vacancy**-Human Resources Business Partners are working on the top 10 vacancies as part of the workforce improvement plan and focusing on the hard to recruit areas..
- **Appraisals**- A refreshed appraisal drive is underway to work with divisions to increase the uptake of appraisals, reinforcing the value add and best practice approach. Trajectories have been developed and visibility at performance and board meetings where teams are held to accountable .Non-medical Appraisal Rate is at 71.3% which is a slight recovery from previous month A slight change to reporting parameters has been introduced this month to remove staff who are Long Term Sick.
- MAST –Mast Compliance is at 89.4% so a slight upturn. The focus primarily for June will be continuing to support the Information Governance Team to try and meet their target of 95% by the date of the Data Security Protection Toolkit Audit to NHS Digital (end of June)..
- Stability – A Living Our Values subgroup has been set up to further discuss and engage with staff on the behaviour framework as well as subsequent workshops and materials. The Staff Survey Big 5 subgroups have been formed and been meeting with their Executive Sponsors to agree actions. The local staff survey reports have been cascaded down to a Care Group level, and reports and supporting materials have been made available for all staff to access via our Trust intranet.

Workforce Metrics

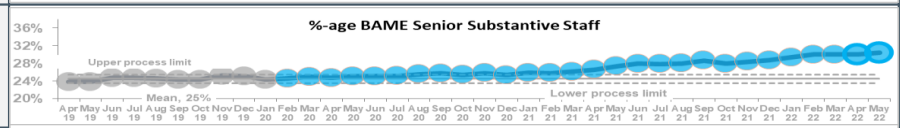
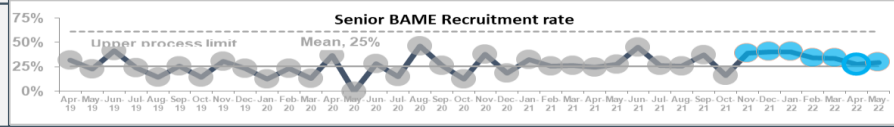
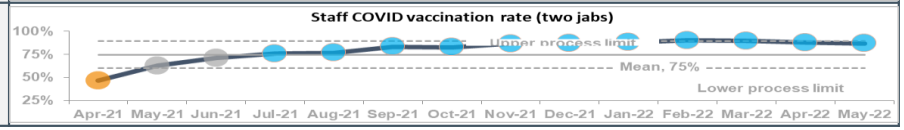
- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

Metrics	May-22	Target	Var to target	Trend
Trust Level Sickness Rate	3.95%	3.2%	-0.75%	
Trust Vacancy Rate	9.4%	10.0%	+0.6%	
Trust Turnover Rate* Excludes Junior Doctors	17.1%	13.0%	-4.1%	
IPR Appraisal Rate - Medical Staff	81.92%	90.0%	-8.08%	
IPR Appraisal Rate - Non Medical Staff	71.3%	90.0%	-18.7%	
Overall MAST Compliance %	89.4%	85.0%	+4.4%	
Trust Stability Index	79.1%	85.0%	-5.9%	

Our People Perspective

Diversity & Inclusion, Culture Metrics

- Common cause variation
- Special cause variation – improving performance
- Special cause variation – deteriorating performance
- Special cause improvement 6-point ascending/descending run
- Special cause concern 6-point ascending/descending run

	Metrics.	May-22	Target	Var to target	Trend
✓	Internal Hire Rate (all bands)	42.7%	40%	+2.7%	
NA	%-age BAME Senior Substantive Staff (Band 8 and up)	30.4%	N/A	-	
NA	Senior BAME Recruitment rate (Band 8 and up)	29.4%	N/A	-	
!	COVID-19 Staff vaccination rate (both Jabs)	86.3%	90%	-3.7%	

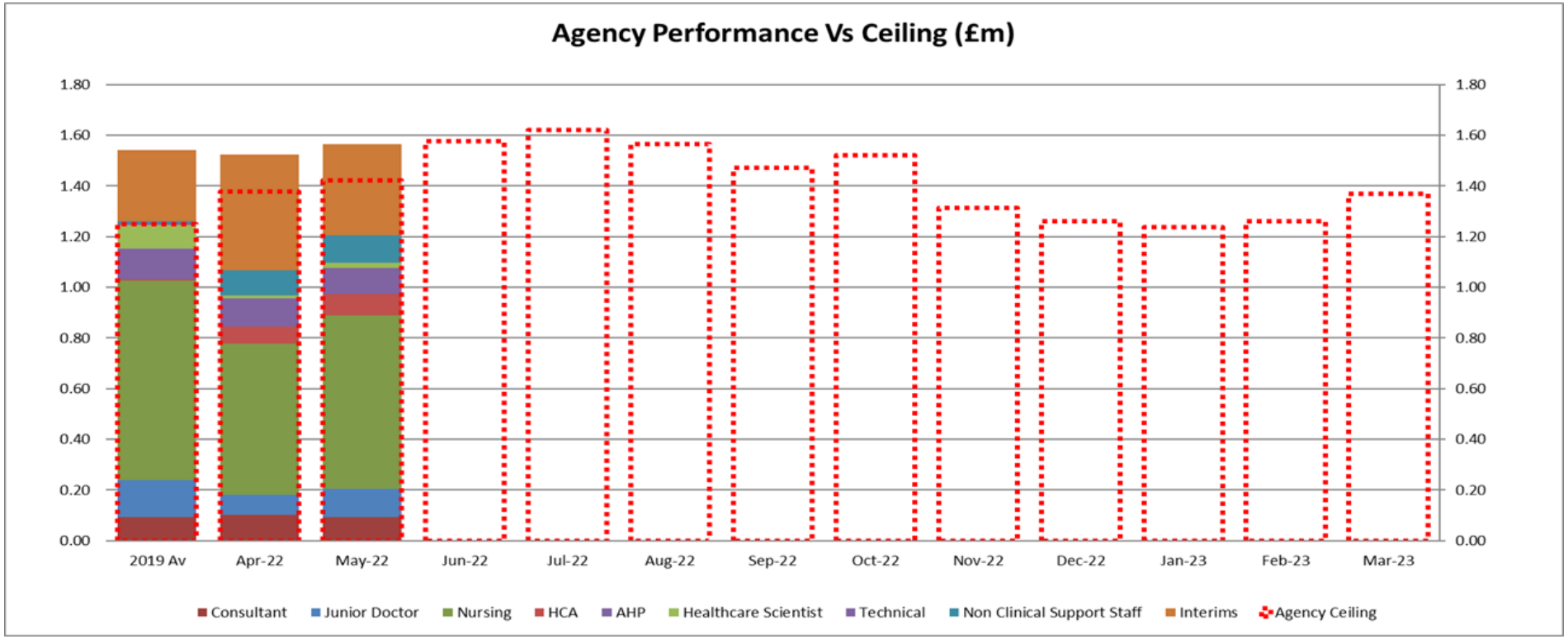
What the information tells us

- In May the Internal hire rate was 42.7% a reduction of 8% on last month showing special cause variation with an improving position.
- International nurses expected Mid May and June. We are continuing to work with Capital Nurse and there are 234 new starters with Booked start dates in May.
- Of the Senior substantive staff (Band 8 and above) employed in the trust, Black and Minority Ethnic staff represent 30.4% of that group. The Senior BAME recruitment rate for staff 8 and above increased this month from 27.6% to 29.4%.
- At time of writing, the COVID-19 vaccination rate was 86.3%.

Actions and Quality Improvement Project .

- Following the quality assurance review and subsequent changes to the monthly reporting template, we are continuing to monitor compliance and investigate instances where a Recruitment Inclusion Specialist has not been present.
- Human Resources is also working closely with Maternity services to provide a bespoke service to increase recruitment activity, reducing Time to hire and with Theatres to do a face to face recruitment event. Our Non nursing division are conducting a collaborative piece of work with Diagnostics
- There is an active communication plan promoting vaccinations for all staff.

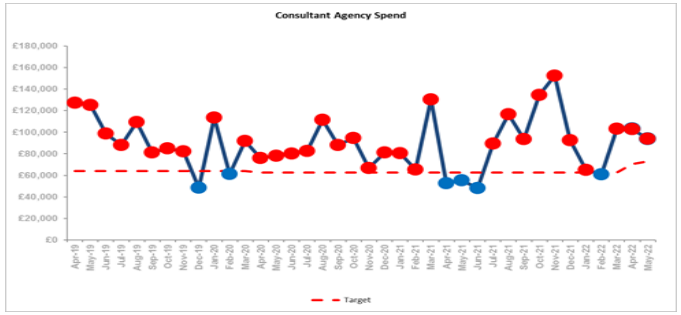
Agency use

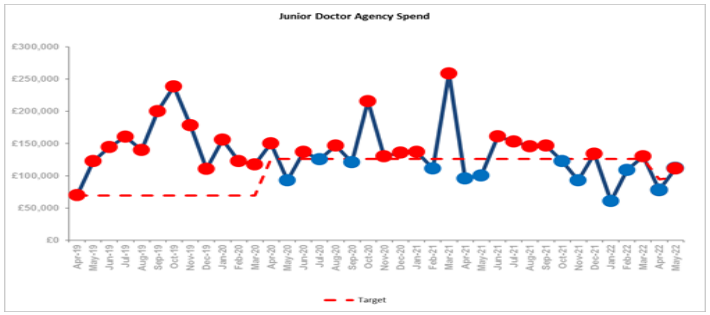


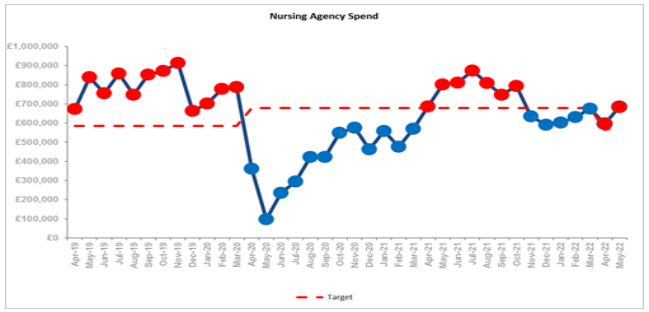
- The Trust's total pay for May was £54.38m. This is £0.42m adverse to plan of £53.96m
- There is an internal annual agency target of £17.00m
- Agency cost for May was £1.56m , the monthly target set is £1.42m
- For February, the monthly target set is £1.25m. The total agency cost is worse than the target by £0.58m
- The biggest areas of overspend were Nursing (£0.10m) , Non Clinical Support Staff (£0.07m) and HCA (£0.07m)

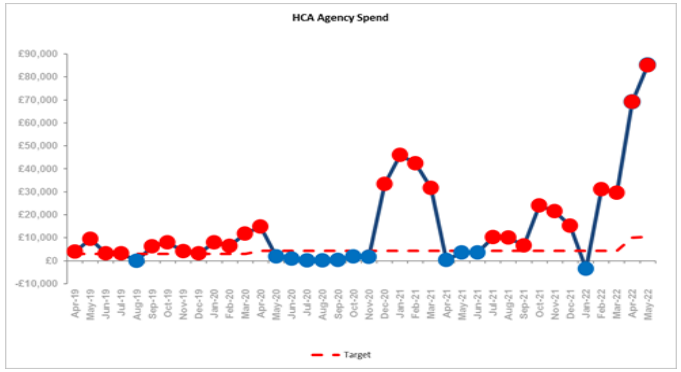
Agency use

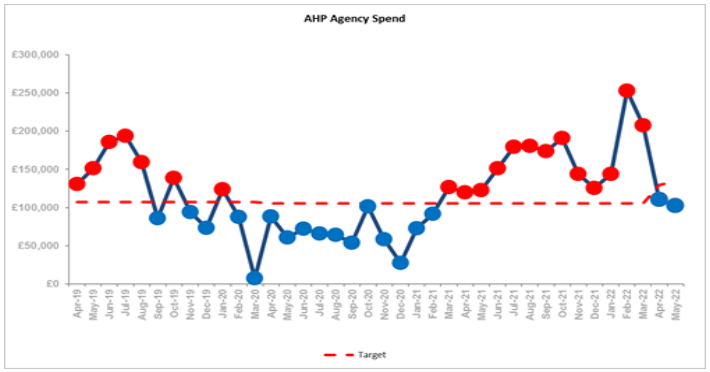
Below cap
Above cap

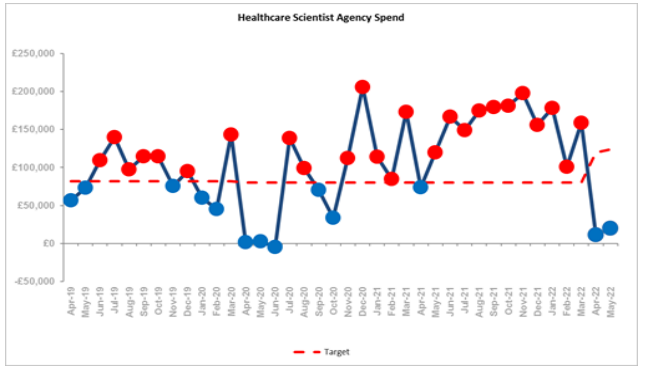


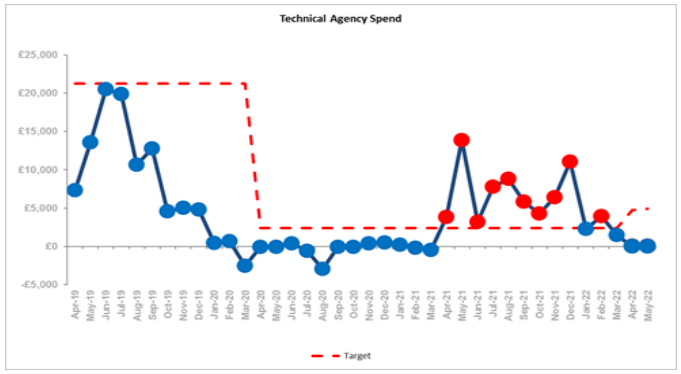


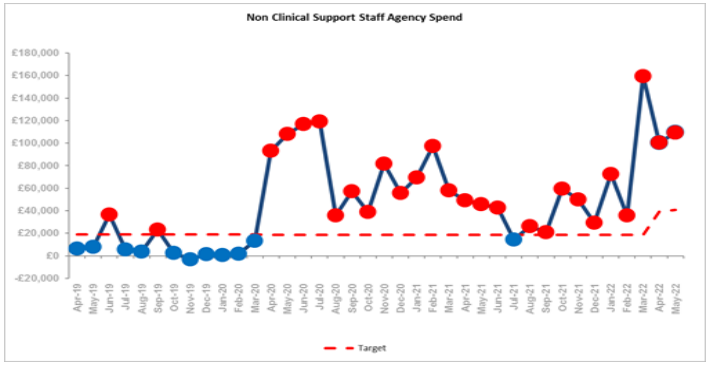


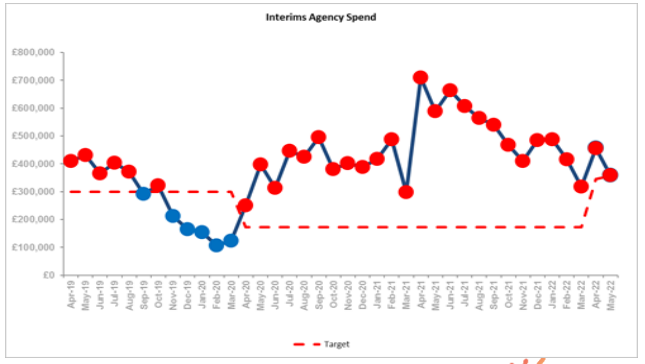








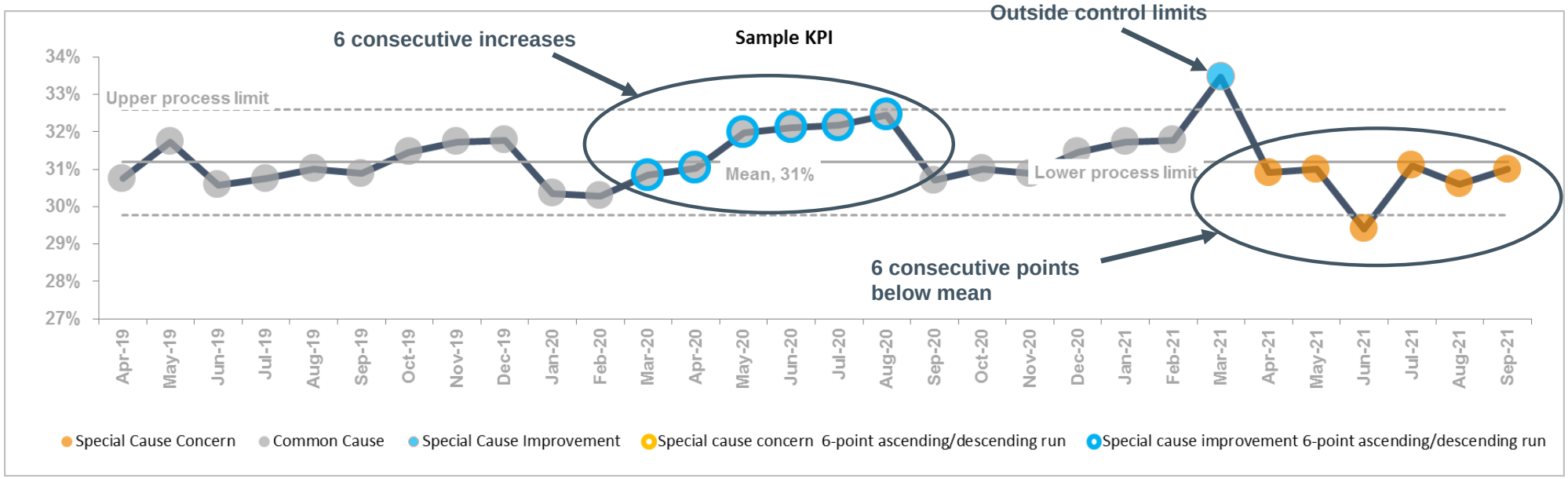




Our People Perspective

Appendix
Additional Information

Interpreting SPC (Statistical Process Control) Charts



SPC Chart – A time series graph to effectively monitor performance over time with three reference lines; Mean, Upper Process Limit and Lower Process Limit. The variance in the data determines the process limits. The charts can be used to identify unusual patterns in the data and special cause variation is the term used when a rule is triggered and advises the user how to react to different types of variation.

Special Cause Variation – A special cause variation in the chart will happen if;

- The performance falls above the upper control limit or below the lower control limit
- 6 or more consecutive points above or below the mean
- 6 or more consecutive increases/decreases
- Any unusual trends within the control limits

Appendix Cancer Performance – April 2022

14 Day Standard Performance by Tumour Site - Target 93%

Tumour Site	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	No of Patients
Brain	93%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	93%	54.5%	78.7%	86.1%	26.9%	17.5%	30.1%	14.5%	10.3%	12.0%	25.3%	26.8%	33.3%	75.5%	269
Children's	93%	100.0%	100.0%	100.0%	100.0%	50.0%	50.0%	90.0%	100.0%	100.0%	50.0%	100.0%	100.0%	100.0%	2
Gynaecology	93%	87.2%	92.6%	91.7%	95.0%	94.5%	85.4%	88.7%	88.1%	91.3%	83.3%	79.2%	89.6%	78.6%	112
Haematology	93%	96.4%	100.0%	95.5%	79.3%	90.9%	100.0%	100.0%	95.8%	94.4%	87.5%	100.0%	100.0%	75.0%	16
Head & Neck	93%	95.7%	96.9%	93.4%	95.5%	88.1%	92.4%	93.8%	91.9%	95.3%	88.5%	89.7%	93.2%	78.4%	148
Lower Gastrointestinal	93%	95.9%	67.6%	82.2%	96.7%	95.7%	98.3%	98.3%	99.6%	100.0%	96.6%	95.4%	90.6%	89.5%	200
Lung	93%	91.9%	97.5%	93.9%	74.3%	68.2%	82.6%	85.7%	74.3%	31.3%	60.0%	76.1%	72.5%	92.5%	40
Skin	93%	93.6%	97.5%	94.5%	91.4%	94.8%	91.0%	93.7%	90.4%	88.8%	79.2%	94.4%	82.1%	76.5%	417
Upper Gastrointestinal	93%	98.1%	96.9%	97.4%	96.6%	97.2%	95.2%	96.8%	96.6%	93.4%	93.5%	94.6%	95.5%	91.1%	101
Urology (Suspected testicular cancer)	93%	89.6%	97.0%	98.3%	98.1%	88.6%	86.6%	94.4%	94.7%	92.1%	95.9%	95.7%	87.3%	75.5%	143

62 Day Standard Performance by Tumour Site - Target 85%

Tumour Site	Target	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	No of Treatments
Brain	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	
Breast	85%	91.7%	78.6%	80.0%	83.3%	66.7%	81.3%	66.7%	54.5%	50.0%	61.5%	60.0%	61.5%	83.3%	12
Children's	85%	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Gynaecology	85%	75.0%	40.0%	60.0%	50.0%	100.0%	66.7%	40.0%	55.6%	16.7%	40.0%	40.0%	40.0%	75.0%	2
Haematology	85%	100.0%	66.7%	50.0%	80.0%	80.0%	100.0%	50.0%	42.9%	50.0%	55.6%	100.0%	75.0%	-	0
Head & Neck	85%	90.9%	46.7%	70.6%	50.0%	86.7%	58.3%	36.4%	56.5%	47.4%	25.0%	29.2%	82.2%	56.3%	8
Lower Gastrointestinal	85%	75.0%	46.2%	66.7%	18.2%	61.5%	70.6%	75.0%	75.0%	46.2%	50.0%	40.0%	66.7%	50.0%	6
Lung	85%	90.9%	100.0%	62.5%	25.0%	100.0%	66.7%	70.6%	70.0%	100.0%	55.6%	25.0%	80.0%	62.5%	4
Skin	85%	78.8%	87.9%	78.8%	76.5%	74.1%	89.5%	72.7%	77.5%	75.9%	70.0%	46.7%	87.5%	75.0%	12
Upper Gastrointestinal	85%	60.0%	-	100.0%	100.0%	25.0%	0.0%	50.0%	0.0%	100.0%	50.0%	50.0%	30.0%	40.0%	5
Urology	85%	56.5%	45.8%	47.8%	69.2%	55.6%	58.1%	81.3%	54.1%	62.9%	58.1%	54.5%	75.6%	85.7%	17.5
Other	85%	100.0%	-	100.0%	50.0%	100.0%	100.0%	100.0%	66.7%	100.0%	100.0%	-	100.0%	80.0%	2.5

RTT Performance – April 2022

Indicator Description	Apr-21	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22
RTT Trust Incomplete Performance (exc UCS)	70.0%	74.2%	76.0%	76.2%	76.0%	76.3%	74.9%	74.2%	72.5%	72.1%	72.1%	72.3%	72.0%
RTT Total Incomplete Waiting Lize Size (exc UCS)	45,109	45,156	45,242	46,319	46,977	47,014	47,667	46,802	47,601	47,892	48,570	48,351	49,329
Total waits greater than 18 weeks (exc UCS)	13,522	11,662	10,850	11,044	11,263	11,121	11,969	12,070	13,093	13,357	13,544	13,416	13,789
Total waits greater than 52 weeks	2,174	1,597	1,240	1,106	1,028	1,005	1,023	959	923	887	802	846	911
RTT Incomplete Performance - Admitted	41.4%	47.1%	48.9%	48.4%	47.0%	46.6%	45.7%	48.3%	48.8%	47.1%	46.6%	46.6%	46.8%
Total waits - Admitted	7,193	7,045	6,809	6,619	6,291	6,293	6,250	6,299	6,630	6,442	6,373	6,500	6,602
Total waits greater than 18 weeks - Admitted	4,213	3,724	3,476	3,415	3,335	3,362	3,396	3,258	3,396	3,409	3,405	3,473	3,511
Total waits greater than 52 weeks - Admitted	1,359	1,067	880	777	702	663	658	619	600	572	541	545	573
RTT Incomplete Performance -Non Admitted	75.4%	79.2%	80.8%	80.8%	80.5%	80.9%	79.3%	78.2%	76.3%	76.0%	76.0%	76.2%	75.9%
Total waits - Non Admitted	37,916	38,111	38,433	39,700	40,686	40,721	41,417	40,503	40,971	41,450	42,197	41,851	42,727
Total waits greater than 18 weeks - Non Admitted	9,309	7,938	7,374	7,629	7,928	7,759	8,573	8,812	9,697	9,948	10,139	9,943	10,278
Total waits greater than 52 weeks - Non Admitted	815	530	360	329	326	342	365	340	323	315	261	301	338

Note: Unknown Clock Starts (UCS) have been excluded from the above metrics. For context the number of UCS in April was 459, compared to 324 in March.

RTT Performance – April 2022

Specialty	Admitted		Non Admitted		Incomplete Pathway					
	Total	% within 18 weeks	Total	% within 18 weeks	Within 18 weeks	Over 18 weeks	Total	% within 18 weeks	Over 42 weeks	Over 52 weeks
General Surgery Service	484	22.3%	1,500	70.1%	1,159	825	1,984	58.4%	98	179
Urology Service	437	65.7%	1,875	88.5%	1,946	366	2,312	84.2%	30	25
Trauma and Orthopaedics Service	259	65.3%	2,007	84.8%	1,871	395	2,266	82.6%	12	3
Ear Nose and Throat Service	510	46.9%	4,488	66.5%	3,223	1,775	4,998	64.5%	221	203
Ophthalmology Service			76	71.1%	54	22	76	71.1%	1	0
Oral Surgery Service	231	45.5%	555	86.8%	587	199	786	74.7%	21	11
Neurosurgical Service	238	50.0%	2,558	60.6%	1,669	1,127	2,796	59.7%	118	38
Plastic Surgery Service	614	36.0%	735	81.2%	818	531	1,349	60.6%	86	86
Cardiothoracic Surgery Service	68	1	166	1	225	9	234	96.2%	0	0
General Internal Medicine Service	1	1	23	47.8%	12	12	24	50.0%	4	0
Gastroenterology Service	466	84.8%	2,682	70.4%	2,284	864	3,148	72.6%	73	6
Cardiology Service	1,411	33.7%	3,494	73.6%	3,049	1,856	4,905	62.2%	250	204
Dermatology Service	3	66.7%	2,653	82.4%	2,187	469	2,656	82.3%	17	1
Respiratory Medicine Service	3	100.0%	1,324	88.3%	1,172	155	1,327	88.3%	1	0
Neurology Service	51	78.4%	2,877	74.6%	2,186	742	2,928	74.7%	31	10
Rheumatology Service	2	1	978	87.5%	858	122	980	87.6%	5	0
Elderly Medicine Service			73	72.6%	53	20	73	72.6%	0	0
Gynaecology Service	246	65.9%	1,863	88.4%	1,808	301	2,109	85.7%	5	0
Other – Medical Services	198	76.3%	7,512	75.7%	5,840	1,870	7,710	75.7%	62	7
Other – Paediatric Services	664	39.9%	2,293	78.3%	2,060	897	2,957	69.7%	34	20
Other – Surgical Services	623	36.9%	2,323	75.1%	1,974	972	2,946	67.0%	105	115
Other – Other Services	93	55.9%	672	67.4%	505	260	765	66.0%	26	3
Grand Total	**6,602**	**46.8%**	**42,727**	**75.9%**	**35,540**	**13,789**	**49,329**	**72.0%**	**1,200**	**911**

The numbers reported above exclude Unknown Clock Starts(UCS)

There are a number of specialties reported under speciality ‘Other’. This follows guidance set out in the documentation, “Recording and reporting referral to treatment (RTT) waiting times for consultant-led elective care” – produced by NHS England.

Early Warning Score

Indicator Description	Threshold	May-21	Jun-21	Jul-21	Aug-21	Sep-21	Oct-21	Nov-21	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
Compliance with appropriate response to EWS (Adults)	100%	88.0%	91.0%	92.3%	91.6%	96.9%	88.5%	89.7%	78.5%	93.1%	92.9%	90.8%	91.5%	77.2%
Number of EWS Patients (Adults)		581	443	531	429	479	532	507	480	362	434	403	505	614

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Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**2.3.1**
Report Title:	**Breast TWR Recovery Update**		
Lead:	Kate Slemeck, Managing Director – St George's		
Report Author:	Kate Slemeck, Managing Director – St George's		
Presented for:	Assure		
Executive Summary:	This paper outlines the current performance position for the breast cancer standards; the continuing gap between demand and capacity; and the actions underway to move the breast cancer pathway to sustainable delivery of the cancer standards. The breast service has made significant improvements in operational processes and provided additional triple assessment clinics over the past 3 quarters to deliver a considerable improvement in delivery of the cancer standards for this tumour site. This has undoubtedly improved patient experience for people referred onto the breast TWR, and the team are to be congratulated on their hard work to achieve the current position. However, there are 2 outstanding actions that are essential to tackle the root causes of the mismatch between demand and capacity on this pathway within existing resources. Progress on these has been slower than expected, reflecting both the focus on recovering the current position but also the historic legacy sensitivities. There are concrete plans in place to fully implement both outstanding actions, with the expectation that this will release additional capacity (and thus recover TWR performance, which will dip July-October 2022) to put this cancer pathway on a sustainable footing. However, the improvements in the Faster Diagnosis Standard and 62 Day Treatment standard are expected to be sustained throughout this period.		
Recommendation:	The Board is asked to note the report.		
Supports			
Trust Strategic Objective:	Care		
CQC Theme:	Safe, Effective, Caring, Responsive and Well-led		
NHS System Oversight Framework:	Well-led		
Implications			
Risk:	Non-compliance with operating standards, delays to treatment.		
Legal/Regulatory:	Operational performance standards are closely monitored as part of our regulatory compliance.		
Resources:	As set out in paper.		
Previously Considered by:		**Date**	
Appendix:	N/A		

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St George's Hospital NHS FT Breast TWR Recovery Update
Trust Board, 7 July 2022

1. Executive Summary

This paper outlines the current performance position for the breast cancer standards; the continuing gap between demand and capacity; and the actions underway to move the breast cancer pathway to sustainable delivery of the cancer standards.

There has been significant improvement in delivery of the 4 national cancer standards over the last six months, as outlined in the table below:

Breast	Dec-21	Jan-22	Feb-22	Mar-22	Apr-22	May-22
TWR	12.30%	25.80%	26.80%	33.60%	75.50%	87.80%
Symptomatic	10.90%	22.80%	20.50%	21.80%	72.10%	81.40%
Faster Diagnosis Standard	31.70%	39.90%	84.00%	83.80%	89.10%	90.30%
62 Day	50%	61.50%	60.00%	61.50%	83.30%	80.00%

Recovery of the backlog has been achieved to date through;

- operational pathway improvements
- additional sessions provided by the breast team, who have worked extremely hard to recover the position to date.

Consistent delivery of the TWR is dependant on further actions being completed, which have not progressed at the pace originally expected. These will be fully implemented in October. This delay reflects the additional work required to embed the following necessary changes;

- in follow-up clinical pathways to ensure that the service is compliant with best practice, and
- in medical job plans to sustainably resolve legacy issues in working patterns

Until these actions are fully embedded, the TWR position cannot be sustained without reliance on significant WLIs to provide additional clinics. Therefore, it is expected that TWR performance will dip in the period July – October, and fully recover by March 2023.

It is crucial to resolve these long-standing challenges to ensure that the service can sustainably meet demand within its clinical capacity and resources. Failure to address the root causes of these challenges will otherwise result in a return to 'boom and bust' demand & capacity management, where current demand is managed through a reliance on WLIs. This is not viable in the long term for the staff affected; nor is it value for money.

However, the strength of the current position against the TWR indicates that the service will continue to meet the Faster Diagnosis Standard throughout this period. This is the more important and key measurement of timely diagnosis which sets up the pathway for treatment in a timely way (optimising clinical outcomes for people diagnosed with breast cancer). The predicted summer dip in TWR performance is not expected to affect the service's compliance with the 62 Day standard in this year, or thereafter.

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2. Current Performance

a. TWR

The 2WW rule (TWR) which indicates patients should be seen within 14 days of referral from their GP has significantly improved to 87.8% in May 2022. The team are ensuring all appointment slots are booked and correct patient tracking is happening to maximise the use of the capacity the service currently has. An improvement from 13% DNA rate to 6% has been delivered.

However, over the summer the TWR position is expected to deteriorate until the outstanding actions to optimise follow-up pathways and address long-standing issues in job plans are completed, and the capacity to demand ratio is corrected sustainably. This is despite the reduced referral rate usually experienced over July and August because of the referral spike in September / October, as depicted below:

Based on predicted referral rates, together with confirmed clinic capacity, it is expected that an additional 390 people will be added to the TWR in the July-October period, with an associated drop in TWR performance of c. 18-23%.

However, current booking performance indicates that the service will be able to sustain the FDS and 62 day performance standards, as outlined below.

A detailed recovery trajectory for the TWR will be confirmed once the PSFU audit and implementation has been completed – however, full and sustained compliance is expected by March 2023.

b. Faster Diagnosis Standard (FDS)

Following the implementation of one-stop model in October 2021 the FDS standard has shown significant improvement in the last 3 months with 90% compliance in May 2022. This has also been improved by clearing the backlog of letters; and ensuring consistent documentation that patients have been advised of their diagnosis before leaving the one stop clinic.

Since the expansion of triple assessment slots, discharge at first appointment has risen to a median of 80%. The median time to first appointment is 14 days and from first seen appointment to diagnosis of cancer 5 days.

It is expected that the service will remain complaint with the 75% standard of all patients having cancer ruled out or diagnosed by day 28 throughout 2022/23.

c. 62-day treatment target

There has been a marked improvement in the delivery of this target, reaching 80% in May 2022. Operational rigour on scheduling and booking has driven this improvement.

The majority of breast TWR referrals are not diagnosed with cancer. However, evidence shows that delays beyond diagnosis by day 28 are rarely recovered – it is the Faster Diagnosis Standard compliance (not compliance with the TWR) which is the most accurate predictor of timely treatment by day 62.

The Trust as part of the cancer recovery programme has agreed a trajectory to meet 80% on the 62 Day Treatment Standard by March 2023 and then compliance of 85% in 2023/24. It is expected that the breast service will meet this trajectory, despite the expected dip in TWR. Ability to achieve this standard prior to April 2023 is being explored and will form part of the updated report to FIC on pathway to green for cancer at St Georges.

3. Actions for Improvement Completed To Date

During 2021/ 22 the Trust invested £320k to provide an additional triple assessment team, reflecting the 6% year on year increase in referrals since 2019. All posts have been recruited into. In October 2021 the service moved to a one-stop triple assessment clinic, in line with best practice. This model ensures all patients receive a full assessment on their first appointment, reducing waiting time and improving efficiency and patient experience. Patients are initially seen by a breast surgeon, a training doctor or an advanced nurse practitioner. Following assessment, further examinations, such as a mammogram and/or an ultrasound scan and a biopsy is performed / taken by a radiologist or Advanced Nurse Practitioners. Results should be provided to the patient on the day of appointment.

The Division also recruited a dedicated deputy general manager for breast services who brought operational rigour to the service. This has reduced the polling range (the range of days' clinic slots are available to be booked into on ERS) from 21 to 12 days. The service has also separately cleared most of its backlog of "off pathway letters" making PTL management more effective.

Staff within the breast service have worked regular WLI sessions to recover the TWR position throughout 2021/22 and the start of the 22/23 financial year. This has equated to £180,000 additional spend.

Mutual aid has been provided by the SWL sector, however now all services in the region are challenged against their cancer standards in breast the balance of risk across SWL has changed, and this mutual aid has stopped.

These actions have delivered the dramatic improvement in performance for the breast cancer pathway. However, without pathway redesign (reduce unnecessary follow-ups to increase diagnostic clinic capacity) and reforms to job plans, this improvement in breast TWR will prove short-lived as it remains heavily reliant on the existing clinical team working additional sessions.

Even though a focus on addressing the root causes of the mismatch between demand and capacity will cause a time-limited dip in TWR performance, it is essential that these more difficult

issues are fully tackled. Only this will provide the breast cancer pathway with sufficient capacity within resources to meet the current demand, and consistently deliver all the cancer standards for this tumour site.

4. Outstanding Actions to Mitigate Demand and Capacity Gap

4.1 Pathway redesign

a. Personalised Stratified Follow Up

Personalised Stratified Follow Up (PSFU) is an effective way of adapting care to the needs of patients after cancer treatment. The implementation of PSFU pathways tailored to individual needs offers huge benefits to patients improving patient experience and quality of life for people following treatment for cancer. PSFU, once implemented can allow a volume of outpatient appointment slots to be redeployed for new referrals.

This is a well-evidenced and established pathway for breast cancer services, and the local pathway for this within the Trust has been designed and endorsed by the breast service clinical team. However, there is a clinical reluctance to roll this out fully before local clinical audit has been completed to provide assurance on implementation to date. Combined with the focus on recovery over the last six months, and long-term staff sickness in key posts, this has significantly slowed the full implementation of this pathway.

This clinical pathway optimisation is essential to enable the service to sustainably meet current demand within its clinical capacity. Together with the review of job plans described below, the full implementation of this pathway is expected to have an impact during October, improving the TWR performance fully by March 2023.

b. Breast Pain Pathway

The breast pain pathway is being trialled in a couple of hospitals in London supported by the Royal Marsden Partnership. St George's are keen to review the outcomes of the pilots and implement a pathway. This is expected to release limited capacity in the triple assessment clinics for TWR referrals.

4.2 Workforce Capacity Alignment to Demand

There are a number of legacy working patterns dating back to the creation of the single breast service within the Trust. These require detailed job planning review and mediation to resolve across the breast surgical and radiology medical workforce. This work is being overseen by the CWDT Divisional Triumvirate, with support from the Site Chief Medical Officer.

5. Conclusions and Recommendations

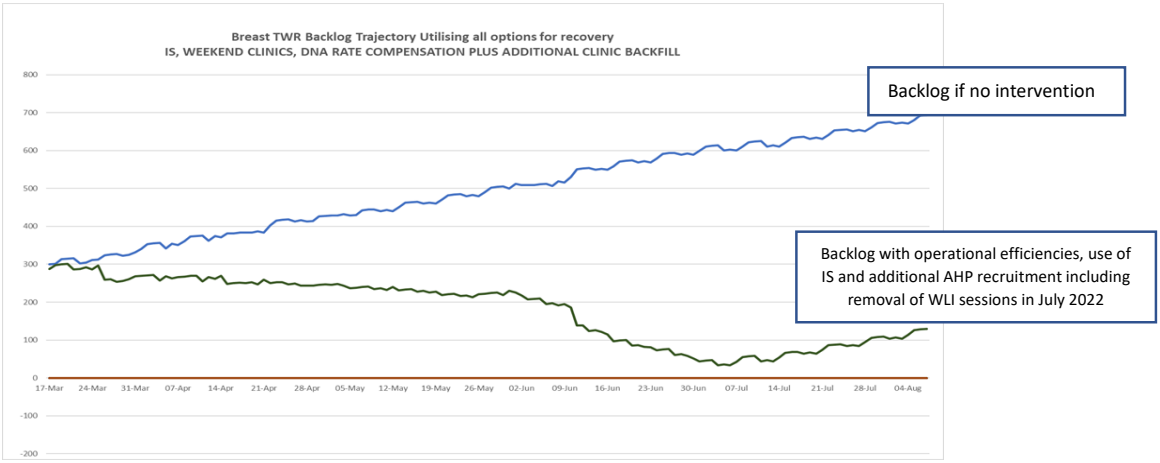
The breast service has made significant improvements in operational processes and provided additional triple assessment clinics over the past 3 quarters to deliver a considerable improvement in delivery of the cancer standards for this tumour site. This has undoubtedly improved patient experience for people referred onto the breast TWR, and the team are to be congratulated on their hard work to achieve the current position.

However, there are 2 outstanding actions that are essential to tackle the root causes of the mismatch between demand and capacity on this pathway within existing resources. Progress on these has been slower than expected, reflecting both the focus on recovering the current position but also the historic legacy sensitivities.

There are concrete plans in place to fully implement both outstanding actions, with the expectation that this will release additional capacity (and thus recover TWR performance, which will dip July-October 2022) to put this cancer pathway on a sustainable footing.

However, the improvements in the Faster Diagnosis Standard and 62 Day Treatment standard are expected to be sustained throughout this period.

Appendix 1 - Feb 2022 Backlog Reduction Trajectory



Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No.**	**3.1**
Report Title:	**People Committee Report**		
Lead Director/ Manager:	Stephen Collier, Chair of People Committee		
Report Author:	Stephen Collier, Chair of People Committee		
Presented for:	Assurance		
Executive Summary:	This Report sets out a summary of the matters reviewed by the Committee at its meetings in May and June. This is the first report from the Trust's newly constituted People Committee, following its adoption of Committee-in-Common working with Epsom and St Helier. The Committee reviewed Strategic Risks 8 and 9 at its May and June meetings. No changes in risk scores or assurances are recommended. However, the Committee has continued to monitor progress on ensuring that all staff who are required to have been through the Disclosure and Barring Service check have been processed. There are still some 300 staff who either do not have a completed DBS check on file, or whose check is time-expired. The Committee endorsed a proposal that this risk receive a risk rating of 16, which will also result in it being added to the Trust's risk register. The Committee notes the progress being made in resolving this, and will continue to monitor the position. I would as Committee Chair observe that Group working is putting very significant additional workload on our senior executive team, and they have risen well to that challenge. But looking ahead, continuation of Group working, the further pressures of financial constraints, hospital activity step-up, and the long term management of some deep operational performance issues across a much broader geographical footprint have the potential to overwhelm a team that is already very stretched. I will continue to monitor this from the People Committee, and would ask other Board members to be focussed on this particular risk.		
Recommendation:	The Board is asked to: • Note the report • Approve the proposed Terms of Reference (appendix 1) • Approve the proposed Annual Work Plan (appendix 2)		
Supports			
Trust Strategic Objective:	Culture		
CQC Theme:	Well Led		
NHS System Oversight Framework:	People, Well Led		

Introduction

This is the first report from the Trust's newly constituted People Committee, following its adoption of Committee-in-Common working with Epsom and St Helier. We are at an early stage in this, and the meetings have yet to settle into an established rhythm. It is clear though that there are advantages in the joint meeting, particularly in being able to cross-refer, make direct comparisons and share learning and experience. It is also clearly helpful to the executive which is operating on a Group (joint) basis.

The Committee Chairs are working collaboratively, and have agreed to alternate the chairing of meetings (rather than Chair their respective Trust's element in each meeting). One challenge that the joint meetings will generate is the ability to deep dive into Trust specific issues (such as the SGH engagement with HEE over recent months). What is therefore likely is that these types of item will be reported to the Committee in Common, but be further scrutinised and progressed outside the Committee – with appropriate reporting back.

This Report summarises issues covered in the People Committee in Common, but reports only on matters relating to St George's University Hospitals NHS FT (unless otherwise indicated).

Risk Assurance

The Committee reviewed Strategic Risks 8 and 9 at its May and June meetings. No changes in risk scores or assurances were recommended.

However, the Committee has continued to monitor progress on ensuring that all staff who are required to have been through the Disclosure and Barring Service check have been processed. There are still some 300 staff who either do not have a completed DBS check on file, or whose check is time-expired. This is as much a patient safety risk as it is a compliance risk. Management is addressing this vigorously via a structured Action Plan, but it is taking longer than expected. The Executive's view was that any lack of engagement from staff without a current DBS was likely to be due to inertia as oppose to anything more sinister. But given the potential risk this represents, the intention is that disciplinary sanctions will be applied to individual staff who do not engage on this.

As a consequence of the time being taken to resolve this, the level of risk that it represents to the Trust has been evaluated. The Committee endorsed a proposal that this risk receive a risk rating of 16, which will also result in it being added to the Trust's risk register. The Committee notes the progress being made in resolving this, and will continue to monitor the position. The Committee's anticipation is that the present risk score will be reduced in the near term, but this will require continued action from the executive.

Separately, I would as Committee Chair observe that Group working is putting very significant additional workload on our senior executive team, and they have risen well to that challenge. But looking ahead, continuation of Group working, the further pressures of financial constraints, hospital activity step-up, and the long term management of some deep operational performance issues across a much broader geographical footprint have the potential to overwhelm a team that is already very stretched. I will continue to monitor this from the People Committee, and would ask other Board members to be focussed on this particular risk.

Governance

At its May meeting, the People Committee adopted new Terms of Reference designed to support its working in common with the ESH People Committee. We have agreed to review these after six months experience of in-common working.

A work plan for the remainder of the Trust year was adopted. This included opportunities to look at issues on a Group-wide basis.

Internal Supply

Sickness absence remains higher than target, although the trend is downward. Of note is that as Covid-related sickness has declined, non-Covid has increased. The executive is addressing this through a more immediate and interventional response to staff absence due to sickness. The cost of sickness absence to the Trust is material, and any improvement in absence rates has a significant positive financial impact. We will monitor progress here.

Appraisal completion rates continue to be edged forward (Medical 78% and Non-Medical 73%) but progress towards the 90% target is slower than expected, and the executive is attempting to speed this up.

We reviewed the performance of the South West London ICS Recruitment Hub. Although its use had brought down the time to fill for roles, there was still evidence that potential new staff were being lost to the Trust during the onboarding process, which still takes too long. The implementation of a new centralised occupational health service with SW London has not been straightforward. We asked for a more detailed report on the performance of the Hub against the standards set in the initial feasibility.

The Committee reviewed the Trust's Workforce Improvement Plan and its proposed governance in some detail. This focuses on high impact (and potentially high-cost) areas including: recruitment; sickness absence; bank and agency staffing; annual leave management; and staff health and wellbeing. A target for efficiency improvement has been set, and the delivery of this is being overseen by three oversight groups, which report to the executive's People Management Group. The Committee has asked for regular updates of progress against plan.

The Committee undertook a deep dive on staff turnover. A very detailed analysis indicated that 43% of Leavers had less than one years service. Across all Leavers, 'Relocation' (21%); 'Work-Life Balance' (15%); and 'Promotion' (19%) were the most frequent reasons for leaving. Of all Leavers, 70% said that they would work at the Trust again, and 65% would recommend it as a place to work. The Committee noted the responses obtained from Leavers also included detailed reasons for leaving, and destination (see Annex 1) – but also their reasons for originally joining the Trust, and what the Trust could do to make their working experience better. The executive is acting on this information. Future Deep Dives will include Sickness Absence, and Employee Relations and Vacancies.

I have over recent weeks chaired two Consultant Appointment panels, and it has been good to see the calibre of individual who have applied for roles at the Trust (including from Consultants in substantive posts at other Trusts).

Staff Engagement

At its June meeting, the Committee reviewed progress and planning on Staff Engagement. This was a detailed report, based on insight from the 2021 Staff Survey – and placed the Trust in a national context. Staff engagement was, of concern, at its lowest point since 2018. Whilst broadly in step with the NHS national average, it was clear that an improvement was required and management set out its plans to achieve this. The plans were thoughtful, and adopted elements of the NHS national People Promise. We have asked for regular updates, and will continue to receive reports on the regular Pulse surveys undertaken within the Trust.

We reviewed the Trust's current position on Facility Time Reporting. It was noted that the level of recorded time dedicated to union representation was lower than might have been expected. However,

the Committee received assurances from the Executive that this was due to the manner in which such activity is recorded as oppose to being a failure by the Trust to release colleagues for this important work. Steps are being taken to improve recording mechanisms.

Culture Diversity and Inclusion, Organisational Development

The Trust's Culture Programme continues its work. A set of 'Big 5' priorities have been chosen in the light of the recent Staff Survey and work was under way on the delivery of these.

We received an update on progress on Speaking Up from Karyn Richards-Wright, the Trust's Guardian. This covered the 21-22 Trust year, in which there had been a 5% increase in concerns raised over the prior year. This rate of growth is however lower than in previous years. As in previous years the concerns were led by issues of leadership, Trust processes, and bullying and harassment. There had also been an increase in the number of concerns raised with a line manager which had not been responded to, or concerns citing long resolution periods with HR investigations. These are not new areas and the Trust management accepted that it should be doing better on this. We noted with approval that additional resource is being made available to the Guardian.

A recent Internal Audit report on the Trusts management of its diversity and inclusion had given a rating of 'reasonable assurance'. The SGH Charity has provided a grant of £20,000 to support the staff networks.

We reviewed the work of the Staff Support Service (SSS), noting the continued increase in the numbers of staff making use of the service and the range of issues being brought to it. Service pressure within the Trust is very real, and the SSS is making a real contribution to helping staff manage this. Its presence on the front line is a critical contributor to staff wellness.

Trust Governance

We continue to receive a report at each meeting from the Trust's People Management Group – this keeps us sighted on new and continuing operational issues and how the executive is managing them. It is an important part of the assurance process, in providing early warning of issues.

Stephen J Collier

Committee Chair, 29 June 2022

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ANNEX 1

Reasons for Leaving 2

The table below sets out how the reporting group rated 14 areas known to affect employee engagement and commitment. The 14 areas are ranked by overall impact on the decision to leave, with the corresponding response distribution.

	Leaving Reason	n	10 20 30 40 50 60 70 80 90 %
1	**Well-Being** Maintaining a work-life balance, workloads which do not cause stress.	84	28 23 41 8
2	**Career Progression** Defined opportunities to advance through the organisation. A sense career progression is taken seriously.	83	28 27 33 12
3	**Personal Growth** Training & development needs are identified and my work provides me with opportunities to stretch myself.	78	26 28 31 15
4	**Vertical Relationship** An approachable, inspirational manager who provides regular feedback and acts as a role model.	71	24 16 38 22
5	**Loyalty & Trust** The organisation acts in the interest of its employees and delivers on promises that are made.	66	22 20 42 16
6	**Cooperation** Individual contributions are recognised & valued by others, and support is freely offered by colleagues.	63	21 32 33 14
7	**Working Conditions** Comfortable working environment with good facilities, and reliable and effective equipment.	52	17 23 47 13
8	**Reward & Recognition** Rewarded fairly, transparently and based on performance. Rewards offered are competitive in the wider market place.	47	16 22 53 9
9	**Job Satisfaction** An interesting and enjoyable job, and one I consider important.	46	15 24 43 18
10	**Organisational Confidence** Working for a successful organisation that is well led, has good people and a strong future.	44	15 17 51 17
11	**Ethical Standards** Belief in the purpose and ethical principles of the organisation, promoting diversity and equal opportunities.	42	14 12 50 24
12	**Communications** A clear sense of the organisation's future direction, and an understanding of why key decisions are being made.	32	11 18 58 13
13	**Independence** Freedom to organise my work and set my own goals. Scope to try new ways of doing things.	27	9 14 56 21
14	**Belonging** Belief in the organisation's mission, vision and values. A sense of pride in working for the organisation.	26	9 15 52 24

Key

Leaving Reason | Contributed to Leaving | Not Applicable | Org Strength

People Committee

Terms of Reference

1. NAME

The Committee shall be known as the People Committee.

2. AUTHORITY

The Committee is constituted as a committee of the Trust's Board of Directors and is authorised by the Board to:

- Act within its terms of reference.
- Seek any information it requires, and all staff are required to cooperate with any request made by the Committee.
- Instruct professional advisors and request the attendance of individuals and authorities from outside the Trust with relevant experience and expertise if it considers this necessary or expedient to the carrying out of its functions.
- Obtain such internal information as is necessary and expedient to the fulfilment of its functions.

3. PURPOSE

The purpose of the Committee is to provide assurance to the Board on the development and delivery of the Trust's strategy and plans for a sustainable workforce that supports the provision of safe, high quality, patient-centred care by:

- Overseeing progress in the development and delivery of workforce, organisational development, and cultural change strategies and plans that support the Trust's strategic priorities in the context of the local Integrated Care System(s) and the Trust's financial and operational plans, and the national NHS People Plan.
- Monitoring workforce key performance indictors and identifying and reviewing themes and trends, seeking assurance that appropriate action is being taken to respond to and learn from these.
- Overseeing the development of a culture that empowers and supports staff to deliver to their best, including in relation to equality, diversity and inclusion, raising concerns, and staff health and wellbeing.
- Overseeing education, training and development plans.
- Monitoring the Trust's engagement with staff and work to improve engagement.
- Seeking assurance that key risks relating to workforce, culture, organisational development, equality, diversity and inclusion, as included on the Board Assurance Framework and the Corporate Risk Register, are being effectively managed and mitigated.
- Providing assurance that legal and regulatory requirements relating to the workforce are met.

- Ensuring appropriate governance arrangements are in place in relation to people, culture and organisational development issues and that the Committee is able to provide the Trust Board with assurance on these matters as appropriate.

4. DUTIES

The Committee's duties as delegated by the Trust Board, include:

Workforce Strategy and planning

- Overseeing the development and delivery of workforce, organisational development, and cultural change strategies that support the Trust's strategic priorities, in the context of the ICS, regional and national position, including the NHS People Plan.
- Reviewing and overseeing the development and delivery of workforce plans aligned to the Trust and ICS strategies to provide assurance that the Trust has adequate staff with the necessary skills and competencies to meet the future needs of patients and service users.
- Reviewing and seeking assurance in relation to risks to the delivery of the Trust's workforce strategy and plans.

Workforce performance, themes and trends

- Receiving reports relating to the Trust's workforce performance indicators and providing assurance that any necessary corrective plans and actions are in place. This includes indicators relating to: recruitment and retention, vacancy, turnover, sickness absence, use of bank and agency staff, appraisal rates, education and training, employee relations, and diversity and inclusion metrics.
- Overseeing and reviewing key themes and trends in relation to workforce performance and improvement, and escalating these to the Board as appropriate.
- Overseeing the working hours of junior medical staff and actions to drive improvements, including receiving reports from the Guardian of Safe Working.

Staff engagement and wellbeing

- Providing oversight of plans to improve engagement by the Trust with its staff, with the aim of securing increasing levels of staff engagement.
- Reviewing the results of the annual NHS staff survey and overseeing the development and implementation of action plans to address issues identified.
- Monitoring staff health and wellbeing, including the Trust's plans to ensure that staff are supported to deliver to their best.
- Reviewing the key trends and themes arising from concerns raised by staff, and receiving regular reports from the Freedom to Speak Up Guardian.

Culture, Organisational Development, Equality, Diversity and Inclusion

- Overseeing the development and delivery of the Trust's action plans to strengthen culture, equality, diversity and inclusion and monitoring performance in relation to equality indicators drawing relevant issues to the attention of the Board.
- Monitoring and providing assurance to the Board on the actions taken by the Trust to comply with the Equality Act 2010 in relation to its staff. The Quality

Committee will monitor the Trust's compliance with the Equality Act 2010 in relation to patients.

- Overseeing actions taken by the Trust to comply with relevant regulatory frameworks relating to equality, diversity and inclusion.
- Receiving regular reports relating to equality, diversity and inclusion in the Trust, and reviewing prior to consideration by the Board:
    - the Workforce Race Equality Standard (WRES) and improvement action plans.
    - the Workforce Disability Equality Standard (WDES) and improvement action plans.
    - The Trust's performance in relation to the gender pay gap and the ethnicity pay gap.
- Overseeing actions taken by the Trust to raise the profile of equality, diversity and inclusion across the Trust.
- Overseeing and seeking assurance in relation to the Trust's plans for organisational development.
- Receive reports and action plans relating to independent reviews commissioned by the Trust, or externally, to address significant cultural challenges within teams / services across the Trust.

Education, Training and Development

- Overseeing and seeking assurance in relation to the development and implementation of strategies and plans for education, training and development across the Trust and in partnership with other organisations.
- Overseeing performance on staff appraisal rates (clinical and non-clinical).
- Overseeing performance in relation to statutory, mandatory and other training.
- Overseeing and seeking assurance in relation to the Trust's plans for leadership development.

General

- Referring any matter to any other Board Committee and respond to items referred to the Committee from other Board Committees.
- Obtaining assurance on the risks to delivery of the Trust's corporate objectives in relation to workforce, organisational development, culture, and equality and diversity with a particular focus on issues that are cross-cutting or trust-wide, or specific issues which should be reviewed at the committee.
- Reviewing material findings arising from internal and external audit reports covering matters within the Committee's remit and seek assurance that appropriate actions are taken in response.
- Ensuring there is a system in place to review and approve relevant policies and procedures that fall within the remit of the Committee.
- Receiving and review reports on significant concerns or adverse findings highlighted by regulators, peer review exercises, surveys and other external bodies in relation to areas under the remit of the Committee, seeking assurance that appropriate action is being taken to address these.

- Reviewing any Trust strategies (as shown at **Error! Reference source not found.**) prior to approval by the Board (if required) and monitor their implementation and progress.

5. CHAIR AND MEMBERSHIP

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief People Officer is the executive lead for the Committee.

Membership of the Committee comprises:

- Four Non-Executive Directors (including the Chair)
- Group Chief People Officer
- Group Chief Nursing Officer / Group Chief Medical Officer
- Managing Director(s)
- Group Chief Finance Officer

The following are expected to attend but will not be counted towards quoracy.

- Deputy Chief People Officer – Culture and Organisational Development
- Deputy Chief People Officer – HR Operations
- Director of People Strategy, Planning and Change
- People Director (Site)
- Trust Chief Medical Officer
- Trust Chief Nursing Officer
- Group Chief Corporate Affairs Officer

Other directors and staff may attend meetings with the prior permission of the Chair.

6. REQUIREMENTS OF MEMBERSHIP

All members and attendees named above are expected to attend every meeting with a minimum attendance of 75% over the course of a financial year.

7. QUORACY

In order to achieve quoracy:

- At least two non-executive directors must be in attendance
- At least two executive directors must be in attendance.

Non-quorate meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decision made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting or the Board.

8. DECLARATIONS OF INTEREST

All members and those in attendance must declare any actual or potential conflicts of interest which will be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the meeting for the duration of the discussion.

The Board has approved the potential conflict relating to those members who are also directors for Epsom and St Helier University Hospitals NHS Trust, so this will not need to be declared at each meeting under normal circumstances.

9. MEETING FREQUENCY

The Committee will meet monthly and ahead of Trust Board meetings so that a report to the Board can be provided and any advice on material matters given. Additional meetings may be called by the Chair as necessary, who may also cancel or rearrange meetings in exceptional circumstances

10. RELATIONSHIP WITH OTHER COMMITTEES

People Committee is a committee of the Trust Board and sits alongside other committees of the Board as shown at Appendix A.

11. MEETING ARRANGEMENTS AND SECRETARIAL

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the People Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

12. REPORTING

The Committee Chair will provide a report to the Board on the meetings that have taken place since the last Board meeting. This will include a list of items covered and brief narrative descriptions of the topics the Committee Chair considers should be brought to the Trust Board's attention.

An annual report of effectiveness will be prepared by the Committee for review by the Audit Committee and the Board.

13. REVIEW OF TERMS OF REFERENCE

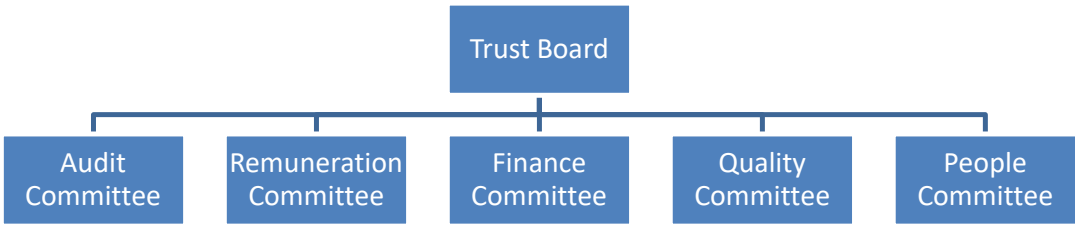
These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and adherence to the Committee's forward plan.

14. DOCUMENT CONTROL

Profile	
Document name	People Committee, Terms of Reference
Version	0.2
Executive Sponsor	Group Chief People Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Quality Committee approval	
Date of Trust Board approval	
Date for next review	

Appendix A

Relationship with Other Committees



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DRAFT People Committee Work Plan 2022/23

HEADING	ITEM NO.	ITEM	LEAD	ACTION	FORMAT	FREQUENCY	May 2022	Jun 2022	Jul 2022	Aug 2022	Sep 2022	Oct 2022	Nov 2022	Dec 2022	Jan 2023	Feb 2023	Mar 2023
OPENING ADMINISTRATION	1.1	Welcome and Apologies	Committee Chair	Note	Verbal	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
OPENING ADMINISTRATION	1.2	Declarations of Interest	All	Note	Verbal	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
OPENING ADMINISTRATION	1.3	Minutes of Previous Meeting	Committee Chair	Approve	Report	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
OPENING ADMINISTRATION	1.4	Matters Arising and Action Log	Committee Chair	Note	Report	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
DEEP DIVES	2.1	Place holder	GCPO	Assure	Report	Bi-monthly		Y		Y		Y		Y		Y	
INTERNAL SUPPLY	3.1	Workforce Key Performance Indicators Report (Monthly focus rhythm: ER, Recruitment, Agency/Bank, Absence)	GCPO	Assure	Report	Monthly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
INTERNAL SUPPLY	3.2	Safe Staffing: Nurse Establishment*	GCNO	Assure	Report	Annually				Y							
INTERNAL SUPPLY	3.3	Medical Revalidation*	GCMO	Endorse	Report	Annual				Y							
INTERNAL SUPPLY	3.4	Nursing Revalidation*	GCNO	Endorse	Report	Annual				Y							
INTERNAL SUPPLY	3.5	Guardian of Safe Working *	GCMO/GSW	Assure	Report	Quarterly				Y			Y			Y	
INTERNAL SUPPLY	3.6	Payroll Dashboard	GCPO	Assure	Report	Bi-monthly	Y		Y		Y		Y		Y		Y
INTERNAL SUPPLY	3.7	Disclosure and Barring Service Update	GCPO	Assure	Report	Bi-monthly	Y		Y		Y		Y		Y		Y
INTERNAL SUPPLY	3.8	Workforce Improvement Plan Update	GCPO	GCPO	GCPO	GCPO		Y		Y		Y		Y		Y	
UP-SKILLING EXISTING WORKFORCE	4.1	Learning and Development: Management Capability	DECOD	Note	Report	Bi-annually		Y							Y		
UP-SKILLING EXISTING WORKFORCE	4.2	Learning and Development: Developing Our People	DECOD	Note	Report	Bi-annually		Y							Y		
UP-SKILLING EXISTING WORKFORCE	4.3	General Medical Council National Training Survey	GCMO	Assure	Report	Annually				Y							
UP-SKILLING EXISTING WORKFORCE	4.4	Undergraduate Medical Education	GCMO	Assure	Report	Annually						Y					
UP-SKILLING EXISTING WORKFORCE	4.5	Learning from the Junior Doctor workforce experience	CMO	Assure	Report	Annually								Y			
WORKKFORCE PLANNING	5.1	Workforce Planning	GCPO	Note	Report	Bi-annually						Y					Y
WORKKFORCE PLANNING	5.2	Updates on South West London and Surrey Integrated Care Systems Workforce Priorities and Developments	GCPO	Note	Report	Quarterly	Y			Y			Y			Y	
HEALTH & WELLBEING	6.1	Staff Health & Wellbeing Report	SHWL	Note	Report	Quarterly	Y			Y			Y			Y	
HEALTH & WELLBEING	6.2	Flu Vaccination Programme	GCNO	Note	Report	Bi-annually						Y					Y
STAFF ENGAGEMENT	7.1	NHS Staff Survey (Results / Planning)*	GCPO/SEL	Note	Report	Bi-annually					Y					Y	
STAFF ENGAGEMENT	7.2	Staff Engagement Update (inc. pulse survey)	GCPO/SEL	Note	Report	Quarterly		Y			Y			Y			Y
STAFF ENGAGEMENT	7.3	Staff Engagement Annual Report	GCPO/SEL	Note	Report	Annually											Y
CULTURE, DIVERSITY & INCLUSION AND OD	8.1	Diversity & inclusion Update	GCPO/DIL	Note	Report	Bi-monthly	Y		Y		Y		Y		Y		Y
CULTURE, DIVERSITY & INCLUSION AND OD	8.2	Freedom to Speak Up Guardian Report*	GCCAO/FTSUG	Assure	Report	Quarterly		Y			Y			Y			Y
CULTURE, DIVERSITY & INCLUSION AND OD	8.3	Workforce Race Equality Standards Annual Report (review prior to submission)*	GCPO/DIL	Endorse	Report	Annually			Y								
CULTURE, DIVERSITY & INCLUSION AND OD	8.4	WRES Action Plan Mid-Year Review	GCPO/DIL	Assure	Report	Annual										Y	
CULTURE, DIVERSITY & INCLUSION AND OD	8.5	Workforce Disability Education Standards Annual Report*	GCPO/DIL	Endorse	Report	Annually				Y							
CULTURE, DIVERSITY & INCLUSION AND OD	8.6	Gender Pay Gap Annual Report*	GCPO/DIL	Endorse	Report	Annually										Y	
CULTURE, DIVERSITY & INCLUSION AND OD	8.7	Ethnicity Pay Gap Annual Report*	GCPO/DIL	Endorse	Report	Annually										Y	
CULTURE, DIVERSITY & INCLUSION AND OD	8.8	Leadership and Culture Programme Report*	GCPO	Assure	Report	Bi-annually		Y						Y			
CULTURE, DIVERSITY & INCLUSION AND OD	8.9	Public Sector Equality Duty Annual Report*	GCPO	Endorse	Report	Annual									Y		
STRATEGY AND RISK	9.1	Workforce Strategy Implementation and Delivery	GCPO	Note	Report	Bi-annually		Y						Y			
STRATEGY AND RISK	9.2	Education Strategy Implementation and Delivery	GCPO	Note	Report	Bi-annually				Y						Y	
STRATEGY AND RISK	9.3	Corporate Risk Register	GCCAO / GCPO	Note	Report	Monthly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
STRATEGY AND RISK	9.4	Board Assurance Framework (People)	GCCAO	Note	Report	Bi-monthly		Y		Y		Y		Y		Y	
TRUST GOVERNANCE & COMPLIANCE	10.1	People Management Group Report	GCPO	Note	Report	Monthly	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
TRUST GOVERNANCE & COMPLIANCE	10.2	Culture, Diversity and Inclusion Programme Board Report	DECOD	Note	Report	Bi-monthly	Y		Y		Y		Y		Y		Y
TRUST GOVERNANCE & COMPLIANCE	10.3	Facility Time Reporting	GCPO	Note	Report	Annually		Y									
TRUST GOVERNANCE & COMPLIANCE	10.6	Modern Slavery Annual Statement	GCPO	Endorse	Report	Annually								Y			
TRUST GOVERNANCE & COMPLIANCE	10.7	Trust-Wide Policies Update - Workforce, OD, Education Focus	GCCAO	Note	Report	Bi-annually					Y						Y
COMMITTEE GOVERNANCE	11.1	Review of Committee effectiveness (Plan)	GCCAO	Note	Report	Annually									Y		
COMMITTEE GOVERNANCE	11.2	Review of Committee effectiveness (Results)	GCCAO	Note	Report	Annually											Y
COMMITTEE GOVERNANCE	11.3	Review of Committee Terms of Reference	GCCAO	Note	Report	Annually											Y
COMMITTEE GOVERNANCE	11.4	Review of Committee Forward work plan	GCCAO	Approve	Report	Annually											Y
COMMITTEE GOVERNANCE	11.5	Committee annual report to the Board	Committee Chair	Note	Report	Annually											Y
CLOSING ADMINISTRATION	99.1	Any Other Business	All	Note	Verbal	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CLOSING ADMINISTRATION	99.2	Draft Agenda for Next Meeting		Note	Report	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CLOSING ADMINISTRATION	99.3	New Risks or Issues Identified		Note	Verbal	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
CLOSING ADMINISTRATION	99.4	Reflections on the Meeting	All	Note	Verbal	Every meeting	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**4.1**
Report Title:	**Audit Committee Report**		
Lead Director/ Manager:	Peter Kane, Chair of the Audit Committee		
Report Author:	Peter Kane, Chair of the Audit Committee		
Presented for:	Review		
Executive Summary:	The report sets out the key issues discussed and agreed by the Committee at its meetings on 10 May and 14 June 2022.		
Recommendation:	The Board is asked to: • Note the report of the Committee's meetings held on 101 May and 14 June 2022; • Approve the proposed changes to the Committee's Terms of Reference; and • Approve the Committee's proposed work plan for 2022/23.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well Led		
Single Oversight Framework Theme:	Finance and use of resources, Leadership and Improvement capability (Well Led)		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1: Revised Audit Committee Terms of Reference Appendix 2: Audit Committee Annual Work Plan 2022/23		

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St George's University Hospitals NHS Foundation Trust

Audit Committee Report
7 July 2022

Matters for the Board's attention

The Audit Committee met on 10 May and 14 June 2022 and agreed to bring the following matters to the attention of the Board.

1. Year-end and Annual Report and Accounts 2021/22

Following its previous approval of the audit plan and fees, accounting policies, and approach to the production of the annual report and accounts at its February meeting, the Committee continued its scrutiny of the year-end process at its May and June meetings:

- In May, the Committee reviewed a report from the external auditors setting out the management responses to the auditors' enquiries. This enabled the Committee to review the responses provided and raise any issues, and the Committee considered this a helpful way of informing its scrutiny of the audit.

- The Committee was assured that the audit process had gone well and that there was effective working between management and the auditors. At its meeting in June, the Committee reviewed the Trust's accounts as well as the external audit findings report and value for money report. It was pleased to note the auditors' unqualified opinion on the accounts and their conclusions that there were no significant weaknesses in the Trust's financial sustainability, governance, or arrangements to improve economy, efficiency and effectiveness.

- The Committee was likewise pleased to receive the Head of Internal Audit Opinion which provided reasonable assurance that the Trust had in place effective governance, risk and internal control arrangements. It noted, however, that among the internal audit reviews conducted in-year, there were a higher number of recommendations relating to governance processes than would have been expected. While these were not related to the overall corporate governance of the Trust, the Committee was keen to understand whether there were common themes in these recommendations and further work will be undertaken to explore this.

- A high level narrative informing the annual report was considered by the Committee at its meeting in May and a full draft of the report had subsequently been shared with Committee members for comment. At its meeting in June, the Committee reviewed the final draft annual report and agreed to recommend approval to the Board, noting that the report provided an accurate reflection of the Trust's performance and that the external auditors had provided assurance that the report complied with the relevant regulatory requirements.

- In the absence of external audit assurance of the Quality Report 2021/22, following changes introduced to streamline governance during the first phase of the pandemic, the Committee was assured that robust scrutiny of the Quality Report had been undertaken by the Quality Committee. The Audit Committee reviewed the report and agreed to recommend its approval to the Board.

2. Internal Auditors Reports

The Committee considered the following reports from internal auditors:

- Internal Auditors Progress Reports and Recommendation Tracker
- Clinical Systems Data Quality (Reasonable Assurance)
- Diversity and inclusion (Reasonable Assurance)

- Infection Prevention and Control (Reasonable Assurance)
- Financial Reporting (Substantial Assurance)

Of the four internal audits reviewed, three were rated as '*reasonable assurance'* and the management had reasonable plans in place to address any outstanding issues. In relation to diversity and inclusion, the Committee noted that a number of improvements had been made since the previous *'limited assurance'* rating in this area. However, there remained scope for further progress and the Committee noted that the audit had focused on processes rather than outcomes and agreed that further work focusing on outcomes was necessary. The Committee commended the finance team for the *'substantial* assurance' rating for financial reporting and reflected on the opportunities to share good practice across the group.

The Committee was pleased to note that there had been progress in addressing outstanding and overdue internal audit recommendations, and a number of these had either been reviewed and the due date revised or implemented and closed. The internal auditors informed the Committee that having a lead officer as a conduit assists in gaining management responses at a faster pace, though there were some areas where obtaining prompt responses remained challenging.

3. Internal Compliance and Assurance

3.1. Breaches & Waivers

The Committee considered the regular breaches and waivers report. It was reported appropriate structures and processes were in place but the Trust had had to use more waivers than ideal at the end of the financial year. The new Oracle financial system was expected to help improve processes.

3.2. Counter Fraud Quarterly Report

The Committee considered a report on progress with current counter fraud cases under investigation. Reviews of timesheet fraud and Covid cost code reviews had been completed, and a report was being drafted on the review of end-to-end procurement processes. The Committee heard that there had been some challenges in getting counter fraud training included on the list of mandatory and statutory training but following resolution of this over 450 staff had completed training.

The Committee considered self-assessment prepared by the Local Counter Fraud Specialist and noted that the Trust was fully compliant on eight of the 13 areas, and was expected to be fully compliant by the end of Q2 2022/23. The Committee reviewed and approved the counter fraud work plan for 2022/23 and noted that the Trust would continue to use Audit One for support and for the delivery of the plan over the coming year.

4. Committee governance

The Committee reviewed its terms of reference and annual work plan for 2022/23. Minor amendments were proposed to the terms of reference, which the Committee endorsed and proposes that the Board approve. These related to minor changes to terminology and roles in the context of the group as well as defining a role for the Committee in providing oversight of the robustness of the Trust's governance, risk and internal control processes in the context of the group. While this did not require changes to the way in which the Committee works, it was important to be clear about the important role the Committee played in providing assurance to the Board on these issues given that the two trusts within the group remain separate legal entities.

Recommendation

The Board is asked to:

- Note the report of the Committee's meetings held on 10 May and 14 June 2022;
- Approve the proposed changes to the Committee's Terms of Reference; and
- Approve the Committee's proposed work plan for 2022/23.

Peter Kane
Audit Committee Chair, NED
July 2022

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NHS
St George's University Hospitals
NHS Foundation Trust

Audit Committee

Terms of Reference

1. NAME

The Committee shall be known as the Quality Committee.

2. AUTHORITY

The Committee is constituted as a committee of the Trust's Board of Directors and is authorised by the Board to:

- Investigate any activity within its terms of reference
- Seek any information it requires and all staff are required to cooperate with any request made by the Committee
- Request attendance of individuals and authorities from inside and outside the Trust with relevant experience and expertise if it considers this is necessary.

This is a standing, statutory Committee. Such a Committee can only be disbanded or its remit amended on the authority of the Board.

3. PURPOSE

The Audit Committee shall provide the Board of Directors with an independent and objective review of financial and corporate governance, assurance processes and risk management across the whole of the Trust's activities (clinical and non-clinical) both generally and in support of the Annual Governance Statement. In addition, it shall oversee the work programmes for external and internal audit and receive assurance of their independence and monitor the Trust's arrangements for corporate governance. The Committee shall also review the integrity of financial statements prepared in support of the Trust's Annual Accounts and oversee the production of the Annual Report and Accounts on behalf of the Board.

The Committee plays a key role in ensuring the Trust is well led and governed effectively and that it has in place the systems, internal controls and risk assurance processes that enable the Trust to deliver on its strategic and corporate objectives. In exercising its duties the Committee supports the Trust in achieving its vision of delivering outstanding care, every time.

4. DUTIES

The Committee's duties as delegated by the Trust Board, include:

Patient Experience

- Monitoring patient experience through the 'Friends and Family Test', national and local surveys, complaints and compliments.
- Monitoring and overseeing issues relating to equality, diversity and inclusion in relation to all matters of patient safety and quality, including access to care and health inequalities.

The Audit Committee will discharge the following duties on behalf of the Board of Directors:

Governance, Internal Control and Risk Management
The Committee shall review the establishment and maintenance of an effective system of integrated governance, internal control and risk management across the whole of the Trust's activities (both clinical and non-clinical) that supports the achievement of the Trust's objectives. In particular, the Committee shall:

i. Review the risk and control related disclosures statements prior to endorsement by the Board. This shall include the Annual Governance Statement, Head of Internal Audit Opinion, External Audit Opinion and / or other appropriate independent assurances.
ii. Ensure the provision and maintenance of an effective system of financial risk identification and associated controls, reporting and governance structure.
iii. Maintain an oversight of the Trust's general risk management structures, processes and responsibilities especially in relation to the achievement of the Trust's strategic and corporate objectives and provide assurance to the Board on the effectiveness of these.
iv. Oversee the robustness of the arrangements for providing the Board with assurance on the strategic risks identified in the Board Assurance Framework
v. Receive reports from other assurance committees of the Board regarding their oversight of risks relevant to their activities and assurances received regarding controls to mitigate those risks. This shall include the clinical audit programme overseen by the Trust's Quality and Safety Committee.
vi. Review the adequacy and effectiveness of policies and procedures: (a) by which staff may, in confidence, raise concerns about possible improprieties or any other matters of concern, (b) to ensure compliance with relevant regulatory, legal and conduct requirements.
vii. Oversee and provide assurance to the Board on the robustness of the Trust's governance, internal control and risk management arrangements in relation to the Trust's participation in the St George's, Epsom and St Helier University Hospitals and Health Group.

Internal audit
The Committee shall ensure that there is an effective internal audit function that meets mandatory standards and provides appropriate independent assurance to the Committee, Chief Executive and the Board of Directors. It shall achieve this by:

i. Reviewing and approving the Internal Audit strategy and annual Internal Audit plan to ensure that it is consistent with the audit needs of the Trust (as identified in the Assurance Framework)
ii. Consider the major findings of internal audit work, their implications and the management's response and the implementation of recommendations and ensuring coordination between the work of internal audit and external audit to optimise audit resources.
iii. Conduct a regular review of the effectiveness of the internal audit function.
iv. Periodically consider the provision, cost and independence of the internal audit service.

External audit
The Committee shall review the findings of the external auditors and consider the implications and management's response to their work. In particular, the Committee shall:

i. Discuss and agree with the external auditor, before the audit commences, the nature and scope of the external audit as set out in the external audit plan and ensure coordination with other external auditors in the local health economy, including the evaluation of audit risks and resulting impact on the audit fee.
ii. Review external audit reports including the report to those charged with governance and agree the annual audit letter before submission to the Board.
iii. Agree any work undertaken outside the annual external audit plan (and consider the management response and implementation of recommendations).
iv. Ensure the Trust has satisfactory arrangements in place to engage the external auditor to support non-audit services which do not affect the external auditor's independence.

The Committee shall also work with the Council of Governors on the appointment or retention of the external auditors.

Financial reporting and accounts review
The Committee shall ensure that the systems for financial reporting to the Board, including those of budgetary control, are subject to the completeness and accuracy of the information provided to the Board. The Committee shall review financial reporting through the year and the financial statements and annual report before submission to the Board. Particularly focusing on:

i. The wording of the Annual Governance Statement and any other disclosures relevant to the terms of reference of the Committee.
ii. All narrative sections of the Annual Report to satisfy itself that a fair and balanced picture is presented which is neither misleading nor consistent with information presented elsewhere in the document.
iii. Changes in, and compliance with, accounting policies, practices and estimation techniques.
iv. The meaning and significance of the figures, notes and significant changes.
v. Areas where judgement has been exercised and any qualitative aspects of financial reporting.
vi. Explanation of estimates or provisions having material effect.
vii. The schedule of losses and special payments, ensuring these have received appropriate approval.
viii. Any unadjusted (mis)statements.
ix. Significant adjustments arising from the audit.
x. Any reservations and disagreements between the external auditors and management which have not been satisfactorily resolved.
xi. The Letter of Representation.

In line with the Trust's Scheme of Delegation (sections 11.1 and 11.2) the Committee shall also monitor the integrity of the Trust's financial statements of the Trust, and

any formal announcements relating to the Trust's financial performance, reviewing significant financial reporting judgements contained in them, to ensure the completeness and accuracy of information provided to the Board.

Counter Fraud, Bribery and Corruption Arrangements
The Committee shall ensure that the Trust has in place:

i. Adequate measures to comply with the Directions to NHS Bodies and Special Health Authorities respect of Counter Fraud 2017.
ii. Appropriate arrangements to implement the requirements of the Bribery Act 2010.
iii. A means by which suspected acts of fraud, corruption or bribery can be reported.

The Committee shall review the adequacy and effectiveness of policies and procedures in respect of counter fraud, bribery and corruption.

The Committee shall formally receive an annual report summarising the work conducted by the Local Counter Fraud Specialist for the reporting year in line with the Secretary of State's Directions.

Raising concerns
The Committee shall review arrangements that allow staff of the Trust and other individuals where relevant, to raise, in confidence, concerns about possible improprieties in matters of financial reporting and control, clinical quality, patient safety or other matters to ensure that:

i. there are systems in place that allow individuals or groups to draw formal attention to practices that are unethical or violate internal or external policies, rules or regulations.
ii. arrangements are in place for the proportionate and independent investigation of such matters and for appropriate follow-up action.
iii. concerns are promptly addressed.
iv. safeguards for those who raise concerns are in place and operating effectively.

General governance

i. On behalf of the Board of Directors, review the operation of and proposed changes to the standing orders, standing financial instructions, codes of conduct, standards of business conduct and the maintenance of registers.
ii. Examine any significant departure from the requirements of the foregoing, whether those departures relate to a failing, overruling or suspension.
iii. Review the schemes of delegation and authority.
iv. Review compliance against the Constitution, Licence and Code of Governance.
v. Review the Trust's governance, internal control and risk management arrangements in the context of the St George's, Epsom and St Helier University Hospitals and Health Group.

Management
The Committee shall request and review reports and positive assurance from directors and managers on the overall arrangements for governance, risk management and internal control and may also request specific reports from individual functions within the Trust as necessary.

Annual work plan and Committee effectiveness
Agree an annual work plan with the Trust Board based on the Committee's purpose (above) and conduct an annual review of the Committee's effectiveness and achievement of the Committee work plan for consideration by the Trust Board.

In exercising its duties, the Committee will provide appropriate challenge and support whilst living the Trust's values.

5. CHAIR

A non-executive director will be Chair of the Committee and in his/her absence, an individual will be nominated by the remaining members of the Committee to chair the meeting.

The Group Chief Corporate Affairs Officer and the Group Chief Finance Officer will be the Executive Leads for the Committee.

6. COMPOSITION OF THE COMMITTEE

The Committee membership comprises three Non-Executive Directors, one of whom is the Committee Chair, and one Associate Non-Executive Director. Only Non-Executive Directors (other than the Trust Chairman) may serve as members of the Audit Committee.

Members are expected to make every effort to attend all meetings and attendance register shall be taken at each meeting. In the absence of the Committee Chair, the Committee should nominate another member to Chair the Committee.

7. ATTENDANCE

The following are regular attendees at the Committee:

- Group Chief Financial Officer
- Group Chief Corporate Affairs Officer
- Managing Director – SGUH
- Deputy Chief Financial Officer
- External Auditors
- Internal Auditors

Other members of the executive team may be required to attend the Committee at the Committee's request. This includes where there is an internal audit review with limited or no assurance, and where an internal control issue has been identified in that director's portfolio.

At the discretion of the Committee Chair, other individuals may be invited to attend on an ad hoc basis or in support of specific agenda items. This would typically include:

- Counter Fraud Lead
- Head of Technical Accounting – for the Annual Accounts
- Group Chief Nursing Officer and/or the Director of Quality Governance and Compliance – for the Quality Account

Deputies can attend the group with the permission of the Committee Chair, though they must be suitably briefed and supported by the individual for whom they are deputising in advance.

8. QUORACY

The quorum for any meeting of the Audit Committee shall be the attendance of a minimum of two members. Regular or other attendees do not count towards the quorum.

Non-Quorate Meetings: Non-quorate meetings may go ahead unless the Chair decides not to proceed. Any decisions made by the non-quorate meeting must however be formally reviewed and ratified at the subsequent quorate meeting.

9. DECLARATIONS OF INTEREST

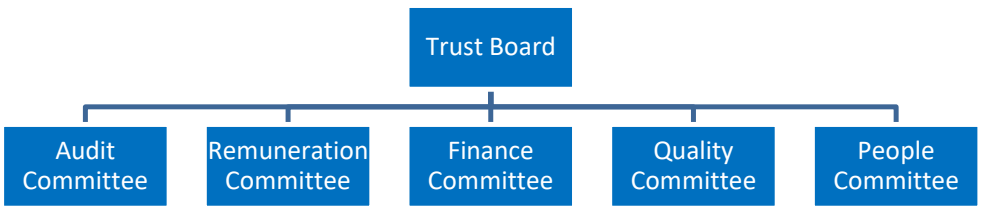
All members and those in attendance must declare any actual or potential conflicts of interest; these shall be recorded in the minutes. Anyone with a relevant or material interest in a matter under consideration must be excluded from the discussion.

10. MEETING FREQUENCY

Meetings of the Committee shall be held quarterly, usually on the fourth Thursday of the month. An additional extraordinary meeting will be held in May or June to review the external auditor's report and recommend the adoption of the annual accounts to the Trust Board. The frequency of meetings may be changed only with the agreement of the Trust Board.

11. RELATIONSHIP WITH OTHER COMMITTEES

The Committee will report to the Board as shown below:



12. MEETING ARRANGEMENTS AND SECRETARIAL

The Group Chief Corporate Affairs Officer will ensure secretarial support is provided for the Audit Committee. This will include the following;

- Preparing a forward plan for the Committee.
- Calling for, collating and distributing meeting papers.
- Taking accurate minutes.
- Producing an action log and chasing completion of actions.

The agenda for the meeting will be agreed with the Committee Chair, based on the forward plan and in conjunction with the executive lead.

All papers and reports to be presented at the Committee must be approved by the relevant executive director.

The agenda and the supporting papers for the meeting will be circulated not less than five working days before the meeting.

13. REPORTING

The Committee Chair will provide a report to the Board on the meetings that have taken place since the last Board meeting. This will include a list of items covered and brief narrative descriptions of the topics the Committee Chair considers should be brought to the Trust Board's attention.

An annual report of effectiveness will be prepared by the Committee for review by the Audit Committee and the Board.

14. AGENDA

Agendas for Committee meeting will be drawn from the Committee's annual cycle of business (forward plan).

15. ANNUAL CYCLE OF BUSINESS

An annual cycle of items and reports to be received by the Committee will be agreed by the Committee. This shall be used to set the agenda for each meeting.

The annual cycle shall be reviewed on an annual basis prior to the start of the financial year and should be reported to the Board alongside the Committee's annual report.

16. REVIEW OF TERMS OF REFERENCE

These Terms of Reference shall be subject to an annual review. This review should consider the performance of the Committee including the delivery of its purpose, compliance with the terms of reference and adherence to the Committee's forward plan.

17. DOCUMENT CONTROL

Profile	
Document name	Audit Committee Terms of Reference
Version	1.3
Executive Sponsor	Group Chief Corporate Affairs Officer, Group Chief Finance Officer
Author	Group Chief Corporate Affairs Officer
Approval	
Date of Audit Committee approval	10 May 2022
Date of Trust Board approval	7 July 2022
Date for next review	April 2023

8

Appendix 2

DRAFT Work Programme
2022/23

MEETING	HEADING	ITEM	LEAD	ACTION	Apr 2022	Jun 2022	Jul 2022	Oct 2022	Jan 2023
AC	OPENING ADMINISTRATION	Welcome and Apologies	Committee Chair	Note	Y	Y	Y	Y	Y
AC	OPENING ADMINISTRATION	Declarations of Interest	All	Note	Y	Y	Y	Y	Y
AC	OPENING ADMINISTRATION	Minutes of Previous Meeting	Committee Chair	Approve	Y		Y	Y	Y
AC	OPENING ADMINISTRATION	Matters Arising and Action Log	Committee Chair	Note	Y		Y	Y	Y
AC	ANNUAL REPORT, QUALITY REPOR	Annual Report, Accounts & Quality Accounts & High level Themes	GCCAO/GCFO	Note	Y				
AC	ANNUAL REPORT, QUALITY REPOR	Annual Report, Accounts & Quality Accounts Plans & Timetables	GCCAO/GCFO	Note					Y
AC	ANNUAL REPORT, QUALITY REPOR	Annual Accounts, Financial Statements, Going Concern Statement includin	GCFO	Approve		Y			
AC	ANNUAL REPORT, QUALITY REPOR	Annual Report including Remuneration, Workforce Report, Annual Govern	GCCAO/GCFO	Discuss	Y				
AC	ANNUAL REPORT, QUALITY REPOR	Annual Quality Accounts (Final)	GCNO	Approve		Y			
AC	ANNUAL REPORT, QUALITY REPOR	Accounting Policies	GCFO	Approve					Y
AC	EXTERNAL AUDIT	External Audit Progress Report	External Auditor	Discuss	Y		Y	Y	Y
AC	EXTERNAL AUDIT	Annual Audit Plan & Fees	External Auditor	Approve					Y
AC	EXTERNAL AUDIT	External Audit Findings (Final)	External Auditor	Endorse		Y			
AC	EXTERNAL AUDIT	Letter of Representation (Financial Audit) (Final)	GCFO	Endorse		Y			
AC	EXTERNAL AUDIT	Reports to Council of Governors - Quality (Account) Report and Limited As	External Auditor	Endorse		Y			
AC	EXTERNAL AUDIT	External Audit Annual Audit Letter	External Auditor	Endorse			Y		
AC	INTERNAL AUDIT	Internal Audit Progress Report	Internal Auditor	Note	Y		Y	Y	Y
AC	INTERNAL AUDIT	Internal Audit Recommendation Tracker	Internal Auditor	Note	Y		Y	Y	Y
AC	INTERNAL AUDIT	Final Internal Audit Review Reports	Internal Auditor	Note	Y		Y	Y	Y
AC	INTERNAL AUDIT	Draft Internal Audit Plan (Draft)	Internal Auditor	Discuss				Y	
AC	INTERNAL AUDIT	Draft Internal Audit Plan (Final)	Internal Auditor	Approve					Y
AC	INTERNAL AUDIT	Draft Annual Report & Head of Internal Audit Opinion (Draft)	Internal Auditor	Endorse	Y				
AC	INTERNAL AUDIT	Draft Annual Report & Head of Internal Audit Opinion (Final)	Internal Auditor	Endorse		Y			
AC	INTERNAL AUDIT	Sector Updates and Digests (including Fraud) (as required)	Internal Auditor	Inform	Y			Y	
AC	COUNTER FRAUD	Counter Fraud Update Quarterly Reports	GCFO	Discuss	Y		Y	Y	Y
AC	COUNTER FRAUD	Counter Fraud Annual Report & Self-Assessment	GCFO	Approve	Y				
AC	COUNTER FRAUD	Counter Fraud Work Plan and Risk Assessment Annual	GCFO	Approve	Y				
AC	COUNTER FRAUD	Review of Anti-Fraud/Anti-Bribery Policy (every three years)	GCFO	Approve					
AC	FINANCE & PROCUREMENT	Losses & Special Payments	GCFO	Endorse	Y			Y	
AC	FINANCE & PROCUREMENT	Breaches & Waivers	GCFO	Endorse	Y		Y	Y	Y
AC	FINANCE & PROCUREMENT	Aged Debt	GCFO	Endorse	Y			Y	
AC	FINANCE & PROCUREMENT	IFRS 176 (Leases) Update on Implementation and Preparations	GCFO	Note				Y	
AC	INFORMATION GOVERNANCE	Information Governance Compliance Update & Annual Report	SIRO	Endorse			Y		
AC	INFORMATION GOVERNANCE	DSP Toolkit: Update (Data Quality/Security)	SIRO	Endorse					Y
AC	RISK MANAGEMENT	Annual Review of Risk Management Strategy & Policy	GCN	Approve					Y
AC	RISK MANAGEMENT	Review of Board Assurance Framework Internal Controls and Governance	GCCAO	Endorse	Y				
AC	CORPORATE GOVERNANCE/COMPI	Review of Internal Auditors Effectiveness	GCCAO	Discuss					Y
AC	CORPORATE GOVERNANCE/COMPI	Standing Orders, Scheme of Delegation & Standing Financial Instructions (	GCCAO/GCFO	Review			Y		
AC	CORPORATE GOVERNANCE/COMPI	Standing Orders, Scheme of Delegation & Standing Financial Instructions (	GCCAO/GCFO	Approve					Y
AC	CORPORATE GOVERNANCE/COMPI	Annual Review of Trust Conflicts of Interest Compliance	GCCAO	Note			Y		
AC	CORPORATE GOVERNANCE/COMPI	Annual Review of Compliance with Trust Policies Protocols	GCCAO	Note				Y	
AC	CORPORATE GOVERNANCE/COMPI	Annual Review of Trust's Clinical Audit Programme	GCN	Note				Y	
AC	CORPORATE GOVERNANCE/COMPI	Freedom to Speak-up Internal Controls and Policies	GCCAO	Endorse					Y
AC	CORPORATE GOVERNANCE/COMPI	Annual Self-Certification with Foundation Trust Licence	GCCAO	Approve	Y				
AC	CORPORATE GOVERNANCE/COMPI	Use of Trust Seal	GCCAO	Note					Y
AC	COMMITTEE GOVERNANCE	Review of Committee Effectiveness (Results of previous year)	GCCAO	Endorse	Y				
AC	COMMITTEE GOVERNANCE	Review of Committee Effectiveness (Plan for current year)	GCCAO	Discuss					Y
AC	COMMITTEE GOVERNANCE	Annual Committee Report to Board including Terms of Reference Update a	GCCAO	Endorse	Y				
AC	CLOSING ADMINISTRATION	Any Other Business	All	Note	Y	Y	Y	Y	Y
AC	CLOSING ADMINISTRATION	New Risks or Issues Identified		Note	Y	Y	Y	Y	Y
AC	CLOSING ADMINISTRATION	Draft Agenda for Next Meeting	Committee Chair	Note	Y		Y	Y	Y
AC	CLOSING ADMINISTRATION	Reflections on the Meeting	All	Note	Y	Y	Y	Y	Y

NB The April meeting has been in held in May this year due to absence

Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**4.2**
Report Title:	**Finance Committee report**		
Lead Director/ Manager:	Ann Beasley, Chair of the Finance Committee		
Report Author:	Ann Beasley, Chair of the Finance Committee		
Presented for:	Assurance		
Executive Summary:	The report sets out the key issues discussed and agreed by the Finance Committee at its meetings on 20th May 2022 and on 24th June 2022		
Recommendation:	The Board is requested to note the update.		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well Led.		
NHS System Oversight Framework:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Previously Considered by:	N/A	**Date:**	N/A
Appendices:	Appendix 1: Green Plan		

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NHS
St George's University Hospitals
NHS Foundation Trust

Finance Committee – May & June 2022

The Committee met on 20th May 2022 & 24th June 2022 as a committee in common with Epsom & St Helier University Hospitals NHS Trust. This paper focuses on agenda items that relate to St George's. In addition to the regular items on strategic risks, operational performance and financial performance, the committee also considered papers on:

- Financial Planning for 2022/23;
- Renal Business Case Update;
- Terms of Reference for the new committees in common;
- A Cyber Security Dashboard Update;
- Finance Policy Updates; and
- An SWLP Report.

As is its usual practice, the Committee discussed the Board Assurance Framework (BAF) risks on a rotating basis by deep dives, with consideration by exception in intervening months. In June members undertook a deep dive into the Finance and Estates risks. Estates issues raised in discussion covered the fire safety risk. In the finance section the committee agreed the proposed increase of SR5 from 20 to 25 to reflect the extreme risk to financial performance in 2022/23. Members were assured that mitigations were receiving sufficient executive focus.

While no deep dive on ICT and Operational risks were presented at the meeting, exception reports highlighted the latest status of cyber security risk and Non-Elective flow in the hospital, with no proposed change to strategic risk 3.

The Committee discussed current financial performance, cash management and capital expenditure as the Trust reported M2 financial performance in 2022/23.

- **The Committee wishes to bring the following items to the Board's attention:**

1.1 Board Assurance Framework Risks – the Group Chief Financial Officer (GCFO) and Director of Estates & Facilities- SGH (DE&F SGH) both updated the committee on their strategic risks, with score and assurance rating agreed as follows:

- SR5- Financial Sustainability 25 – Limited Assurance
- SR6- Financial Investment 20 – Partial Assurance
- SR7- Estates Risk 16 – Partial Assurance

1.2 Estates Report –the Director of Estates & Facilities SGH (DE&F SGH) introduced the normal monthly updates, noting progress on the Premises Assurance model update, and drainage in St James' Wing. He updated the Committee on progress with the Green Plan, appended for information.

1.3 Activity Performance – the COO noted the expected performance against activity trajectories in May, where Daycase/ Elective performance is expected to be slightly below target (at 95% compared to 96% target) and Outpatient performance is expected to be ahead of target (at 110% compared to 96%).

1.4 Emergency Department (ED) Update – the performance of the Emergency Care Operating Standard was recorded at 73.9% in May. The Committee noted that the Trust continues to see significant challenges impacting waiting times, with discussion on staffing resilience.

1.5 Diagnostics Performance – the COO noted that 1.5% of patients were waiting longer than six weeks to have a diagnostic test in May. The Committee welcomed the significant improvement in the performance against this standard.

1.6 Cancer Performance – the COO noted Cancer performance in April, where 3 of the 7 standards were met. The Committee discussed what it would take to achieve all of the standards and asked for a 'path to green plan' at a future meeting.

1.7 Referral to Treatment (RTT) Update – the performance against the RTT target was discussed, where performance in April of 72.0% had deteriorated compared with the previous month's value of 72.3%. The number of patients waiting over 52 weeks was 911, more than the previous month's figure of 846. The size of the waiting list (including QMH patients) was 49,329 patients.

1.8 Financial Performance– the Group Chief Financial Officer (GCFO) noted performance in M2 2022/23, where a YTD deficit of £11.8m was reported in line with the recently resubmitted plan.

He noted the cash balance as at 31st May 2022 was £80.8m, noting the potential challenge on cash should the savings targets later in the year not be delivered.

He also noted the capital position to date was an underspend of £0.6m, with total expenditure at £5.3m.

1.9 Planning 2022-23 – the GCFO noted the progress being made on planning for 2022/23 following resubmission of the external plan on June 20th. The Committee discussed financial mitigations and the work being done with operational teams to deliver CIPs. The Committee observed that the challenge for the Trust was significant, and expressed concern at how deliverable the plan was and the potential impact on quality of services.

1.10 Committee in Common Terms of Reference – the GCFO introduced the Committee TOR approved at Trust Board.

1.11 Cyber Security Dashboard Update – the CIO SGH noted the latest position with the Dashboard, explaining the individual metrics tracked and how the Trust could improve against these. The Committee discussed the use of VDI at the Trust and how this impacted Cyber Security.

1.12 Financial Policies Update – the GCFO noted minor changes to the Business Expenses, Private Patients and Overseas' Policies. **The Committee approved the updated policies.**

1.13 SWLP Report – the DCFO SGH noted the final year end 2021/22 performance of SWLP, which ended £0.5m favourable to plan.

2.0 Recommendation

2.1 The Board is recommended to receive the report from the Finance Committee for information and assurance.

Ann Beasley
Finance Committee Chair,
July 2022

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NHS
St George's University Hospitals
NHS Foundation Trust

Finance and Investment Committee
Estates and Facilities Division
Summary Report

Divisional Overview

May 2022

Andrew Asbury, Director of Estates and Facilities

Estates & Facilities
Directorate Overview

Estate Strategy
- There is still no further update on our NHP EoI. We continue to develop our SOC to cover for any eventuality and cover a wide range of investment options. We are actively engaged with senior clinicians and the executive on our options development and investment objectives.

Capital Projects
- Our current workload on the ICU, MRI and Cath Labs projects are progressing well. We are finding the construction market volatile with some components having variable lead times and delivery delays, such as fire doors, air handling plant and electrical components. We are monitoring our position closely with our professional advisors.

Soft FM
- We are in the process of launching the new National Cleaning standards, working closely with our nursing colleagues and having worked with NHSE/I on the development of the new standards. We are also reviewing cleaning standards at QMH.
- We have been scaling back some of the COVID measures such as manned entrance points, replacing them with Sani-stations. We are monitoring the situation but, barring some minor theft issues, we have not seen a major drop in compliance from staff and visitors.
- We have successfully secured part of the Queen's Green Canopy project and will be planting a tree on site to celebrate the Platinum Jubilee.
- Philip Shelley, Senior Operational & Policy Manager – Soft FM NHSE / I (and co-author on the UK Hospital Food Review and Emma Brookes, Head of Soft FM Strategy & Operation NHSE/I s will be visiting the site on the 7th June as we have been approached as an exemplar NHS site for the collaborative patient meals work with MITIE.

GMB
- We continue to see increased activity from GMB regarding the cleaning contract with Mitie. Our Communications team have been very supportive in countering false accusations made against Mitie in press releases which has dampened down press interest. We are awaiting results of a strike ballot but have contingency plans with Mitie in place. Less than a third of the workforce are believed to be GMB members.

NEPT
- We have had a number of meetings with procurement colleagues to redraw our timelines for NEPT implementation. The main factor will be ESTH's procurement of vehicles which may be subject to delays due to the international microchip shortage. When we have further clarity on this issue we will report accordingly.

HEFMA
- At the time of writing I will shortly be attending with annual HEFMA conference (Health Estates & Facilities Management Association) where Jenni Doman has been shortlisted for Leader of the Year.

Medical Physics
- A recent CQC inspection on IRMA compliance was undertaken, with which the radiation protection team were highly involved, which resulted in favourable feedback for their team.

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Estates & Facilities
Directorate Overview

Green Plan / Sustainability

- We have now welcomed an interim Green Plan Manager to assist with the development of a detailed governance plan and carbon reduction plan over the coming months. We are establishing 9 workstreams aligned with South West London's and our green plan. These are shown overleaf. These 9 workstreams will report into an executive group, chaired by the Site Managing Director.
- Our first significant objective from the Green Plan is to reduce our carbon footprint of the 'NHS Carbon Footprint' by 80% by 2028-32. This footprint comprises of a number of emission contributors, predominantly Scope 1 and 2 emissions, as shown graphically on slide 5.
- The overall NHS footprint has been estimated by NHSE/I extrapolating from known emissions, this has then been calculated for South West London by emission category shown in the pie chart on slide 6. From this data, the emissions of each SWL organisation have been estimated in the critical areas affected by the 2028-32 target (slide 7). Finally, we have RAG rated all the emission areas to help prioritise effort.
- Our current activities are:
    - Assigning carbon emission reduction targets to the 9 workstreams and supporting them with developing a Terms of Reference and action plans for their areas
    - Revalidating our carbon footprint, concentrating on those areas in scope for 2028-32 reduction
    - Within the Estates & Facilities workstream, producing (with WSP) a decarbonisation strategy to describe the scope and cost of the capital projects to convert the Trust to an all electric site (thereby decommissioning the CHP plan) with electric heat and steam generation
    - Ensuring that we are working closely with our finance colleagues to ensure that long term capital and revenue projections to enable this work are understood, together with the clear social and economic benefits
    - Developing a BREEAM strategy for the Trust, ensuring that there is a clear approach for all capital projects
    - Ensuring that any actions identified in the Green Plan have been assigned to one of the 9 workstreams, together with any existing actions underway, and included within the terms of reference.
    - Developing the membership and terms of reference for the executive oversight group that will monitor and report on progress of all of the above
- We are working closely with the Greener NHS team on all of this work and volunteering to become an exemplar site.

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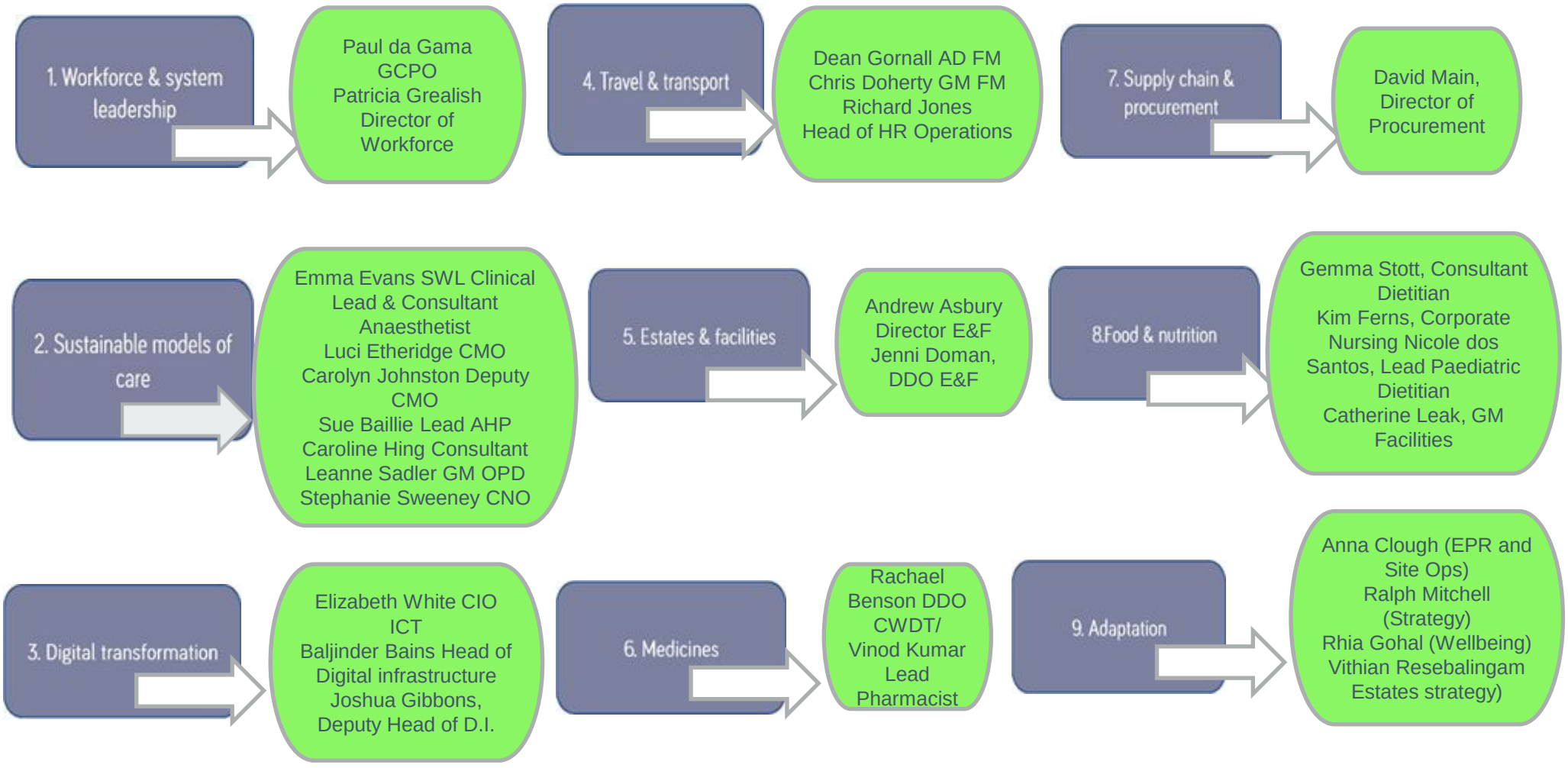

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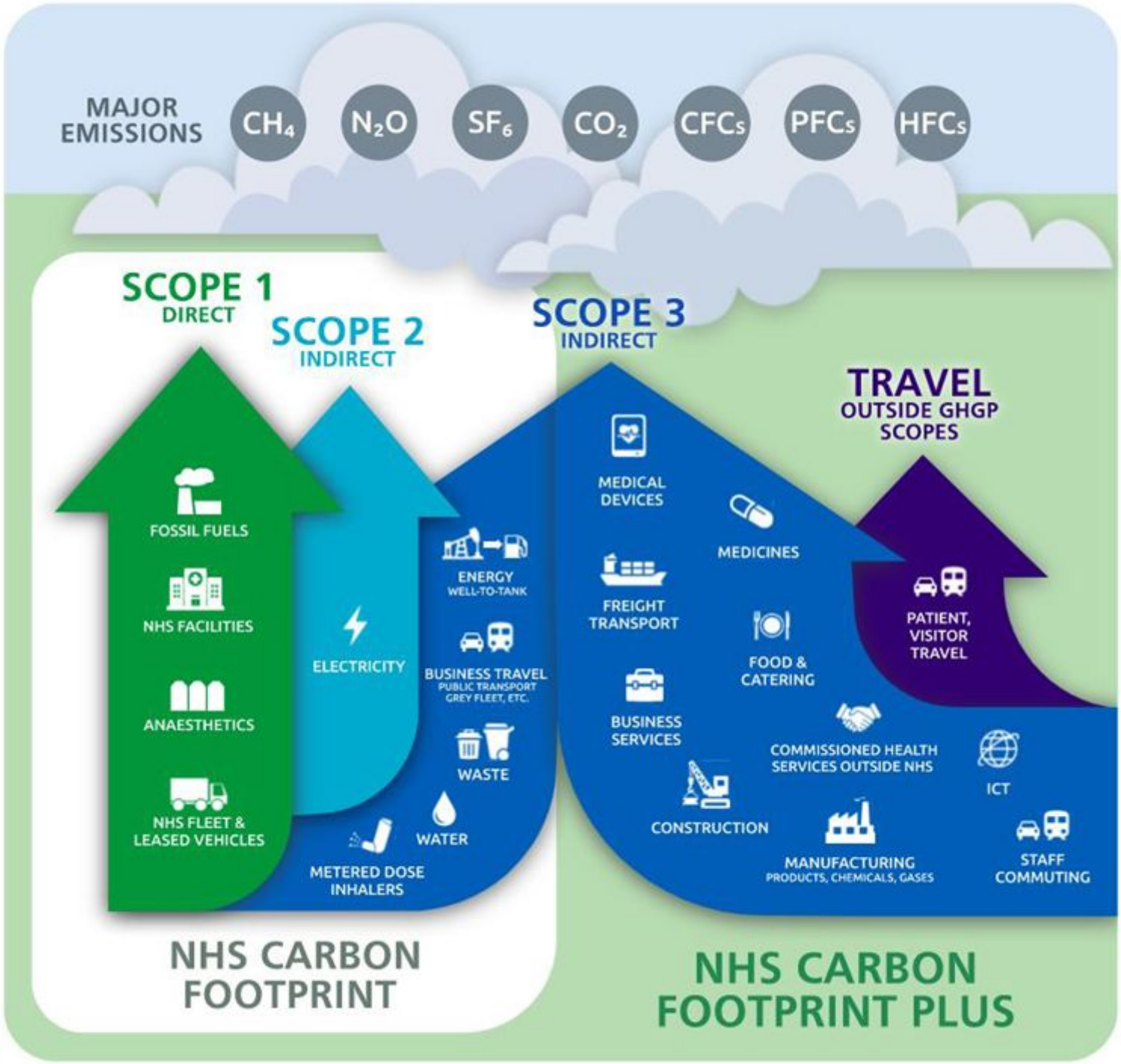

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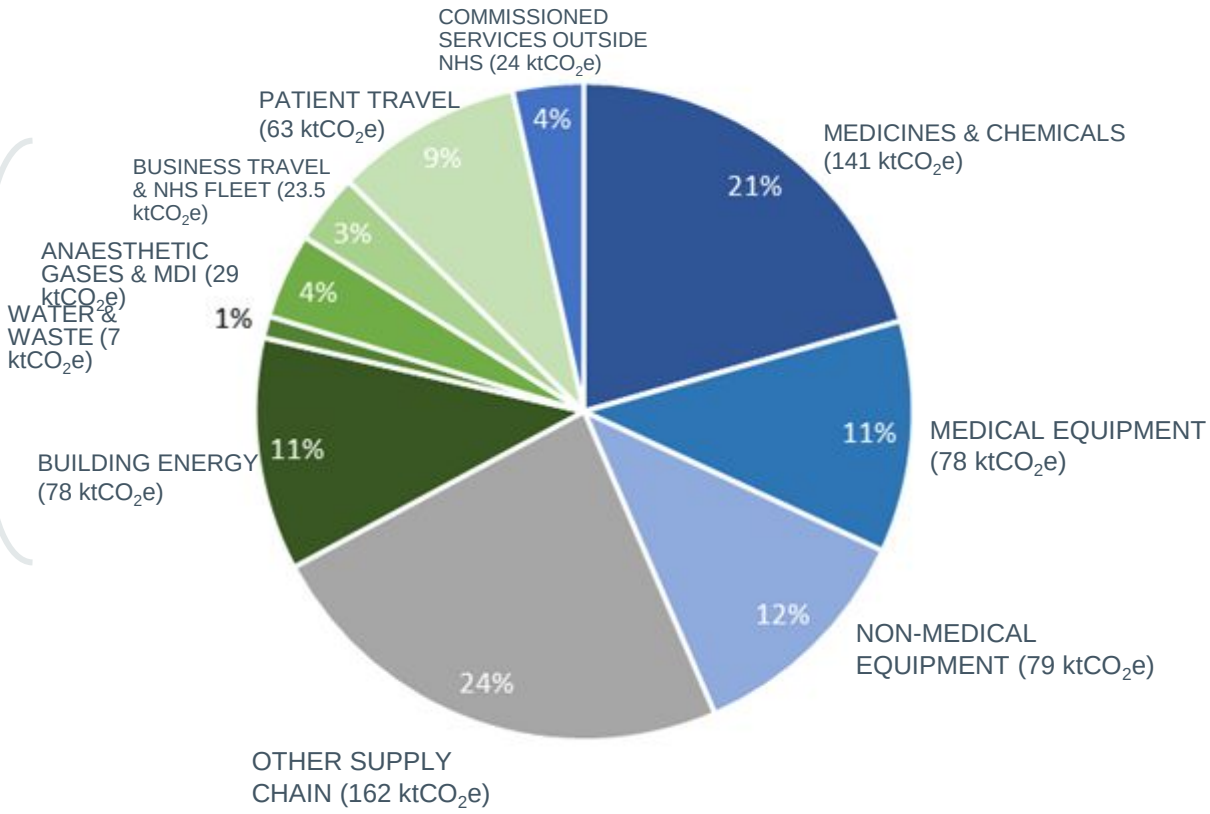
SW London Carbon Footprint Plus (685 $ktCO_2e$)

SWL Carbon Footprint (138 $ktCO_2e$)
London carbon footprint is c. 1 $mtCO_2e$

This is the footprint for reduction by 80% by 2028-32



This has been extrapolated using national percentage figures against known emissions

SW London Baseline core footprint data estimates

2019/20 CO2e Emissions (kilo-tonnes)[1]	Building Energy	Water & Waste	Anaesthetic gases & metered inhalers	Business Travel & NHS Fleet	Total
CLCH[2]	4.5 (1.0e)	0.4 (0.1e)	0.2 (0.1e)	0.5 (0.1e)	5.7 (1.3e)
Croydon	10.7	0.2	1.9	1.6	14.4
Epsom	10.0e	1.0e	2.5e	9.0e	22.5e
HRCH	3.0e	0.4e	0.2e	0.5e	4.1e
Kingston	10.5	1.5	9.8	0.4e	22.2e
Royal Marsden	8.2	0.1	1.4	0.2	9.9
St. George's	29.4	2.4e	12.1e	10.4e	54.3e
St George's Mental Health	5.2e	1.3e	1.0e	1.3e	8.8e
Total[3]	78	7	29	23.5	138

We are currently around 40% of SWL's output
Like all other Trusts, only 20% of our overall carbon footprint is 'accurate' as described above

	Area	Footprint	Ability to Influence	Investment	Overall RAG
CORE	Building Energy	11%			
	Water & Waste	1%			
	Anaesthetic Gases	4%			
	Business Travel / NHS Fleet	3%			
NON CORE	Patient Travel	9%			
	Medicines & Chemicals	21%			
	Medical Equipment	11%			
	Non-Medical Equipment	12%			
	Other Supply Chain	24%			
	Services Outside NHS	4%	n/a	n/a	n/a

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St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**4.3**
Report Title:	Finance Report (Month 2)		
Lead Director/ Manager:	Andrew Grimshaw, Group Chief Finance Officer		
Report Author:	Tom Shearer, Deputy Chief Finance Officer		
Presented for:	Assurance		
Executive Summary:	The Trust is reporting a deficit of £11.8m at the end of May, which is on plan. Income is reported at £1.0m adverse to plan at Month 2. This is due to lower Pathology and R&D income than plan. This is partially offset by additional funding to cover COVID Testing and Vaccination costs. Expenditure is reported at £1.0 favourable to plan at Month 2. This is due to lower Pathology and R&D costs. This is partially offset by higher Medical premium temporary costs. Capital expenditure of £5.3m has been incurred year to date. This is to £0.6m less than the budget of £5.9m At the end of Month 2, the Trust's cash balance was £80.8m. Cash resources are tightly managed and will continue to be monitored.		
Recommendation:	The Board is asked to note the financial performance as per M2 2022/23		
Supports			
Trust Strategic Objective:	Balance the books, invest in our future.		
CQC Theme:	Well-Led		
Single Oversight Framework Theme:	N/A		
Implications			
Risk:	N/A		
Legal/Regulatory:	N/A		
Resources:	N/A		
Equality and Diversity:	There are no equality and diversity impact related to the matters outlined in the report.		
Previously Considered by:	Finance Committee	**Date**	24/6/2022
Appendices:			

NHS
St George's University Hospitals
NHS Foundation Trust

M2 SGUH Financial Performance

GCFO, SGH Site CFO

24th June 2022

Executive Summary SGH

Summary metrics

Area	Key Issues	Current Month (YTD)	Previous Month (YTD)
Financial Position	The Trust is reporting a deficit of £11.8m at the end of May, which is on plan.	On Plan	On Plan
Income	Income is reported at £1.0m adverse to plan at Month 2. This is due to lower Pathology and R&D income than plan. This is partially offset by additional funding to cover COVID Testing and Vaccination costs.	£1.0m Adv to plan	£1.3m Adv to plan
Expenditure	Expenditure is reported at £1.0 favourable to plan at Month 2. This is due to lower Pathology and R&D costs. This is partially offset by higher Medical premium temporary costs.	£1.0m Fav to plan	£1.3m Fav to plan
Cost Improvement Programme	Only modest CIPs are planned for M2. However, pressures in the base budget and the scale of the challenge give cause for considerable concern	To note risk against the scale of the ask	
Capital	Capital expenditure of £5.3m has been incurred year to date. This is to £0.6m less than the budget of £5.9m	£0.6m Fav to plan	
Cash	At the end of Month 2, the Trust's cash balance was £80.8m. Cash resources are tightly managed and will continue to be monitored.	£80.2m £12.2m higher than Y/E	

1. Month 2 Financial Performance

SGH

		Full Year Budget (£m)	M2 Budget (£m)	M2 Actual (£m)	M2 Variance (£m)	YTD Budget (£m)	YTD Actual (£m)	YTD Variance (£m)
Income	SLA Income	865.7	73.8	74.2	0.4	146.2	146.7	0.4
	Other Income	149.6	10.8	10.7	(0.1)	22.9	21.5	(1.5)
Income Total		**1,015.3**	**84.6**	**84.8**	**0.3**	**169.2**	**168.1**	**(1.0)**
Expenditure	Pay	(637.1)	(54.0)	(54.4)	(0.4)	(107.9)	(108.4)	(0.5)
	Non Pay	(357.0)	(30.5)	(30.3)	0.2	(61.0)	(59.5)	1.5
Expenditure Total		**(994.0)**	**(84.5)**	**(84.7)**	**(0.2)**	**(168.9)**	**(168.8)**	**0.1**
Post Ebitda		(72.1)	(6.0)	(6.0)	0.0	(12.0)	(12.0)	0.0
Grand Total		**(50.8)**	**(5.9)**	**(5.9)**	**0.0**	**(11.8)**	**(11.8)**	**(0.0)**

Trust Overview

The in month reported position at **M2 is a £5.9m deficit, which is on plan. The YTD position is a £11.8m deficit, which is on plan**.

- **Income** is £1.0 under plan, with lower Pathology and R&D income being partially offset by additional funding to cover COVID Testing and Vaccination costs.
- **Pay** is £0.5m overspent across Medical staff groups due to premium temporary costs.
- **Non-pay** is £1.5m underspent due to lower Pathology and R&D costs.

2. Balance Sheet as at 31st May 2022

SGH

Statement of Financial Position	M12 March-22 FY 21-22 Actual Audited (£m)	M02 May-22 FY22-23 YTD Actual (£m)	Movement YTD May-22 (£m)
Non current asset			
PPE	399.3	401.6	2.3
On SoFP PFI	51.2	50.8	(0.3)
Intangible Assets	36.8	31.8	(5.0)
Other Non Current Asset	1.4	1.4	0.0
TOTAL NON CURRENT ASSET	**488.7**	**485.6**	**(3.1)**
Current assets			
Stock	15.1	16.3	1.3
Debtors	82.5	95.2	12.7
Cash	68.5	80.8	12.2
Total Current Assets	**166.1**	**192.3**	**26.2**
Current liabilities			
Creditors	(150.1)	(199.5)	(49.5)
Capital creditors	(32.6)	(16.3)	16.3
Int payable creditor	(0.1)	(0.0)	0.1
PDC div creditor	0.0	(2.2)	(2.2)
Provision<1 Year	(0.6)	(0.6)	0.0
Borrowings< 1 year	(61.1)	(5.7)	55.4
Total current liabilities	**(244.4)**	**(224.4)**	**20.1**
Net current assets/-liabilities	**(78.3)**	**(32.1)**	**46.2**
Provisions> 1 year	(2.2)	(2.2)	0.0
Borrowings> 1 year	0.0	(54.9)	(54.9)
Total Long-term liabilities	**(2.2)**	**(57.0)**	**(54.9)**
Net assets	**408.2**	**396.4**	**(11.7)**
Taxpayer's equity			
Public Dividend Capital	565.8	565.8	0.0
Revaluation Reserve	73.6	73.6	0.0
Other reserves	1.2	1.2	0.0
Income & Expenditure Reserve	(232.5)	(244.2)	(11.7)
Total taxpayer's equity	**408.2**	**396.4**	**(11.7)**

M02 FY22-23 YTD Statement of Financial Position

- Fixed assets decreased by £3.1m since March-22. This includes the impact of depreciation £8.5m, partially offset by capital expenditure £5.3m.
- Inventory value increased by £1.3m compared to Mar-22. This is due to increase in central store stock, perfusion cardiac catheter and cardiac pacing stocks.
- Debtors has increased by £12.7m since March 2022, and this is due to high accounts receivables turnover by the Trust from NHS debtors.
- The cash position is £12.2m higher than reported at year-end in March-22. The increase in cash is due to the YTD May-22 payment received from NHS England £60m, NHS SW London CCG £68m, HEE £31m, NHS SE London CCG £5.8m and NHS SU Heartland CCG £4.5m for the block payment, Covid-19 top-up and other invoices. The Trust received HMRC VAT reclaim of £4.6m which is for Feb-22 and Mar-22 VAT return.
- Creditors are £49.5m higher than the figures reported at year-end in March-22. There is a significant increase in Non-NHS Accruals since March-22. Other liabilities (deferred income) increased by £1.3m since March-22. March-22 creditors were low due to HMRC, and NHS Pension liability.
- Capital creditors are £16.3m lower than March-22. This decrease is due to FY 21-22 capital creditors paid in FY22-23.
- No movement in provisions.
- No new borrowing since March-22, including capital finance lease.
- PDC dividend charge creditor increased to £2.2m since March-22. This is due to the M02 YTD PDC dividend charge accrual of £2.2m. This accrual is based on the FY22-23 forecasted PDC dividend charge of £13.2m. No PDC charge payment has been made in the financial year.
- Net taxpayer's equity decreased by £11.7m in M02 YTD. This is mainly due the I&E YTD M02 deficit of £11.7m. M02 YTD I&E deficit, includes finance expense and PDC dividend charges.

3. Month 2 Cash Flow Statement

SGH

Statement of Cash Flow	M02 YTD FY 22-23 Actual £m
Opening Cash balance	**68.5**
Income and expenditure deficit	(11.7)
Depreciation	8.5
Impairment	0.0
Interest payable	0.4
PDC dividend	2.2
Other non-cash items	(0.0)
Operating surplus/(deficit)	**(0.7)**
Change in stock	(1.3)
Change in debtors	(12.7)
Change in creditors	49.5
Change in provisions	0.0
Net change in working capital	**35.5**
Capital spend	(5.3)
Capital Creditors	(16.3)
Capital additions Finance leases	0.0
Interest paid	(0.4)
PDC dividend charge paid	0.0
Net change in investing activities	**(22.0)**
PDC Capital Received	0.0
Accrued Interest YTD (DH & LEEF)	0.0
DH Capital £14.747m Loan repaid	(0.3)
LEEF Loan (Other Loan)	0.0
PFI	(0.2)
Finance lease payments	0.0
Net change in financing activities	**(0.5)**
Cash balance as at 31.05.22	**80.8**

M02 FY22-23 YTD cash movement

- The cumulative M02 22-23 I&E deficit is £11.7m. (*NB this includes the impact of donated grants and depreciation, which is excluded from the NHSI performance total).
- Within the I&E deficit of £11.7m, depreciation (£8.5m) does not impact cash. The charges for interest payable (£0.4m) and PDC dividend (£2.2m) are added back and the amounts actually paid for these expenses shown lower down for presentational purposes. This generates a YTD cash "operating deficit" of £0.7m.
- The net change in working capital is £35.5m in May-22. This is due to major movement in creditors of £49.5m, which is due to the increased Non-NHS accruals and HMRC and NHS Pension liability in May-22 compared to March-22.
- Stock value decreased by £1.3m in May-22 compared to March-22. This is due to significant increase in central store stock, perfusion cardiac catheter and cardiac pacing stocks .
- Trust paid DH Capital loan repayment of £0.3m YTD May-22. No LEEF loan repayment paid in Apr-22 and May-22 . In addition, YTD to May-22, the Trust made a repayment of £0.2m for PFI.
- Capital creditors reduced by £16.3m compared to £32.6m in March-22. No new capital finance lease additions were made YTD May-22.
- No PDC funding received YTD May-22 for FY22-23.

May-22 cash position

- The Trust achieved a cash balance of £80.8m on 31st May-22, £77.8m higher than the £3m minimum cash balance required by NHSI. This is due to the May-22 contracts income including Covid-19 top-up received from CCGs and NHS England.

4. M2 Capital

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The Trust is planning to spend £45.981m on capital expenditure this financial year, including £4.5m on leases.

This spend is to be funded by Internal capital of £21.374m, leases of £4.5m and new PDC allocation of £20.107m. In addition to this there is a planned £500k on donated spend.

The position reported below is as per the plan submitted in May. This will be refreshed at month 3 following submission of the new plan.

Current capital spend is £5.3m, against a plan of £5.9m. This is due to some phasing issues in the plan regarding some IT schemes, which will be corrected in the 20th June plan submission.

Spend Category	Sum of YTD Budget	Sum of YTD Actual	Sum of YTD Variance
Infrastructure	742,664.00	43,020.12	- 699,643.88
IT	1,935,160.00	825,021.40	- 1,110,138.60
ME & Others	1,038,561.00	51,165.63	- 987,395.37
Projects	2,230,435.00	4,411,180.15	2,180,745.15
Grand Total	5,946,820.00	5,330,387.30	- 616,432.70

Outstanding care every time

St George's University Hospitals NHS Foundation Trust

Meeting Title:	**Trust Board**		
Date:	7 July 2022	**Agenda No**	**4.4**
Report Title:	**Board Assurance Framework (BAF) Quarter 1 2022/23 Review**		
Lead Director/ Manager:	Stephen Jones, Group Chief Corporate Affairs Officer		
Report Author:	James Brind, Head of Risk, SGUH Maria Prete, Risk Manager, SGUH		
Presented for:	**Assurance**		
Executive Summary:	This paper presents the Trust Board with the Board Assurance Framework as at Q1 2022/23. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board Committee. The key changes at Q1 are in relation to SR5 financial sustainability: **SR5 – *'We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise efficiency opportunities'*** • Risk score increased from 20 (5c x 4l) to 25 (5c x 5l) • Assurance rating lowered 'Partial' to 'Limited' • These changes are based on the fact that the Trust has in place an annual plan with a break-even position, but the overall scale of the CIP needed to reach breakeven and the material level of unidentified CIP means there is considerable uncertainty that the plan can be delivered. There are no proposed changes to the risk scores or assurance ratings for the other strategic risks on the BAF at Q1 2022/23, though there are a number of changes to actions to address gaps in control and mitigation which are referenced in the report. In relation to the strategic risk reserved to the Board: **SR4 – *'As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients of South West London'*** • There are no changes to the risk score, which remains at 12 (4c x 3l) or to the assurance rating which remains as 'good'. • This is on the basis that the position at Q1 is not materially different in practical terms from the position at Q4 2021/22. The key changes at system level compared with the position at Q4 2021/22 are the commencement of Integrated care Boards on a statutory basis from July 2022, the appointments to roles within the SWL ICB, and the further progress the Trust and ESTH have made in developing the group model.		
	The Board is asked: a) For the Strategic Risk (system working) reserved to itself (SR4): ○ Agree the proposed score of 12 (4C x 3L) (no change) ○ Agree the proposed assurance rating of 'good' (no change)		

	b) For Strategic Risk 5 (financial sustainability), agree to the recommendation of the Finance Committee that the risk score be raised to 25, the maximum risk, and that the assurance rating be lowered to 'limited'; c) For the remaining 8 strategic risks assigned to its Committees to: ○ Agree the proposed risk scores, assurance ratings and statements from the relevant assuring committee ○ Note the progress in mitigating identified gaps in control and assurance d) For all risks, agree the draft year-end target risk scores, recognising that a review of the BAF risks is scheduled for Q2 2022/23.		
Supports			
Trust Strategic Objective:	All		
CQC Theme:	Well led		
Single Oversight Framework Theme:	Quality of Care Leadership and Improvement Capability		
Implications			
Risk:	The strategic risk profile		
Legal/Regulatory:	Compliance with Heath and Social Care Act (2008), Care Quality Commission (Registration Regulations) 2014, the NHS Act 2006, NHSI Single Oversight Framework, Foundation Trust Licence		
Resources:	N/A		
Previously Considered by:	Quality Committee Finance Committee People Committee	**Date**	23.06.2022 24.06.2022 10.06.2022
Equality and diversity:	The BAF reflects agreed risks in relation to quality and diversity and the actions being taken to address these.		
Appendices:	Board Assurance Framework Q1 2022/23		

Outstanding care every time

NHS
St George's University Hospitals
NHS Foundation Trust

Board Assurance Framework 2022/23

Trust Board
BAF Report – Q1 2022/23

Stephen Jones
Group Chief Corporate Affairs Officer

7 July 2022

Executive Summary

1. Purpose

This paper presents the Trust Board with the Board Assurance Framework as at Q1 2022/23 and sets out the proposed risk scores and assurance ratings, as well as the actions being taken to address identified gaps in control and assurance. With the exception of Strategic Risk 4, which is reserved to the Board, the information set out for each strategic risk has been reviewed by the relevant Board sub committee, following review by the responsible sub-Group of the Trust Management Group, and by the Executive Management Team.

2. Background

The Board Assurance Framework (BAF) brings together in one place all of the relevant information on the risks to the delivery of the Board's strategic objectives as set out in its five-year clinical strategy, Delivering Outstanding Care, Every Time. The BAF provides a structured approach for identifying and mapping the main sources of assurance and coordinating them to best effect. It also highlights where there are gaps in assurance and / or ineffective controls that need to be addressed. The BAF provides a framework through which the Board can understand the sources and levels of assurance relevant to the management of its strategic risks, and it provides an evidence-base of effective oversight of risks to the organisation and its strategic objectives.

The Board approved the current strategic risks on the Board Assurance Framework (BAF) at in May 2020. The Board Committees are assigned the Strategic Risks as follows, with Strategic Risk 4 (system working) reserved to the Board:

- Quality Committee: Strategic Risks 1 (patient safety and learning), 2 (clinical governance), and 10 (research)
- Finance Committee: Strategic Risks 3 (operational performance and access, ICT), 5 (financial sustainability), 6 (capital), and 7 (estates)
- People Committee: Strategic Risks 8 (culture) and 9 (workforce)

3. Update at Q1 2022/23:

- **Risk scores:** There are seven extreme risks, one high risks and two moderate risks on the BAF. There is one change to the risk scores from Q4 2021/22:
  - **SR5 (Financial Sustainability):** The risk score has been increased from 20 to 25. This is based on the fact that the Trust has in place an annual plan with a break-even position, but the overall scale of the CIP needed to reach breakeven, the material level of unidentified CIP, and the fact that at the end of Q1 means there is considerable uncertainty that the plan can be delivered.
- **Assurance ratings**: Six of the ten strategic risks currently have a 'good' assurance rating; three have a 'partial' assurance rating, and one has a 'limited' assurance rating. There is one change to the assurance ratings from Q4 2021/22 :
  - **SR5 (Financial Sustainability):** The assurance rating has been lowered from 'partial' at end Q4 2021/22 to 'limited' at Q1 2022/23. This is based on the scale of unidentified CIPs and the uncertainty in whether the break-even financial plan can be delivered.

Executive Summary

- **Target risk scores:** Target risks were initially defined by the Board in September 2020. At Q4 2021/22, the Trust met the established year-end target risk scores for three strategic risks: SR2 (clinical governance), SR4 (system working), and SR7 (estates). While a review of the strategic risks on the BAF is scheduled to be undertaken during Q2 2022/23, and changes to the wording and scope of the risks is likely, it is nonetheless important to define realistic but achievable year-end target risk scores for 2022/23, notwithstanding these likely changes. Draft target risk scores are set out for each strategic risk and on the summary slide on page 4. In summary these are:

    - **SR1 Patient Safety – 12:** This reflects the 2021/22 year-end target risk position and was considered to be realistic on the basis that as the pandemic eases it is likely to be able to reduce the risk score from 16.
    - **SR2 Clinical Governance – 8:** This reflects the current risk score position. A stretching target risk score would be to reduce the risk further by reducing the likelihood score from 2 currently to 1 at year end, producing an overall risk score of 4. In an organisation of our scale and complexity, and with the clinical governance implementation plan having recently been implemented, it may be considered too ambition to have a risk score of for clinical governance by year-end.
    - **SR3 Access to care; ICT – 16:** This reflects the 2021/22 year-end target risk position and is considered to be realistic, if challenging.
    - **SR4 System working – 8:** The 2021/22 year end target risk was 12. The question is whether, given the inherent risks within the system, a reduction to 8 by year end is achievable. It is proposed that a target of 8 is adopted on the basis that from July ICBs have been established on a statutory basis and will further bed in during the year and that during the year we will further strengthen our new group arrangements with ESTH.
    - **SR5 Financial sustainability – 16:** The 2021/22 target risk score of 12 was not met, and at Q1 2022/23 we have increased the risk score to 25. Given the scale of the financial challenge and delivering the balanced plan, a stretching year-end position is proposed as a score of 16, though it is recognised that this will be challenging to meet.
    - **SR6 Capital – 16:** The 2021/22 year-end target risk score was 12 and was not met (the year finished with the score at 20). Given the overcommitment of available capital means there are a significant number of risks that are unaffordable within the current allocation, and there are many schemes and projects required to be delivered within the year 2 to 5 plan that are unaffordable within allocations within SWL, it is proposed that the target year end position is set at 16, recognising that it may not be possible within current allocations to significantly reduce the risk in relation to capital during 2022/23.
    - **SR7 estates – 16:** The 2021/22 target year end risk score of 16 was achieved. It is questionable whether given the scale of the estates risks and the constrained capital available, it will be possible to move the overall risk score down to a 12 by year end. As a result maintaining a score of 16 doe the year is proposed.
    - **SR8 culture – 12:** This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23.
    - **SR9 workforce – 12:** This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23.
    - **SR10 research – 6:** This reflects the 2021/22 year-end target risk score and is proposed to roll forward for 2022/23.

- **Progress in mitigating risks:** Included in the summaries of each strategic risk are overviews of the actions completed to address identified gaps in control and assurance. This is intended to demonstrate the progress achieved in mitigating the strategic risk even where this has not progressed to the point where a change in the risk score can be recommended.

Strategic Risk 4 (system working) is reserved to the Board: The Board is asked to review and confirm the risk score and assurance level for this risk. In May 2021, the Board set the risk score at 12 (4 consequence x 3 likelihood), with an increased assurance rating of 'good' from 'partial' on the basis of the progress achieved in-year. When the Board reviewed the risk score at Q4, it considered that while the Trust had made significant progress in establishing the new group with ESTH and working as part of the SWL ICS, the inherent risks around system working that went beyond the Trust's control warranted the risk score being maintained at 12. During Q1 2022/23, the key changes compared with the position at Q4 2021/22, are the commencement of Integrated care Boards on a statutory basis from July 2022, the appointments to roles within the SWL ICB, and the further progress the Trust and ESTH have made in developing the group model. Given the position at Q1 is not materially different in practical terms from the position at Q4 2021/22, it is proposed the risk score is maintained at 12 (4c x 3l) and the assurance score maintained at 'good'.

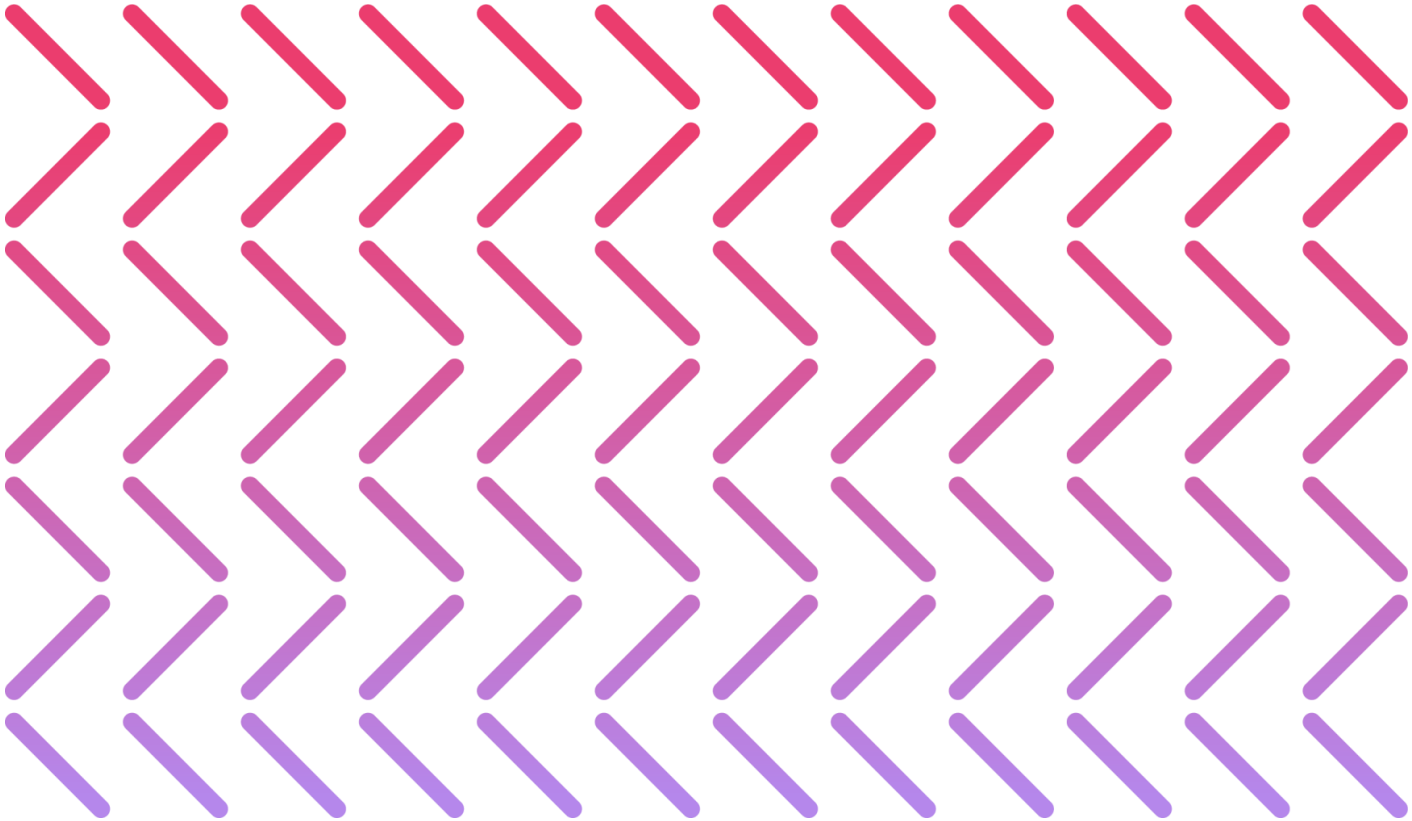
Strategic Risks: High Level Summary – Assurance Rating and Risk Scores

Strategic Objective	Corporate Objective	Risk Reference	2021/22 Strategic Risks	ASSURANCE RATING		RISK RATING		TARGET RISK SCORES	
				Year start (April 2022)	Q1 position 2022/23	Year start (April 2022)	Q1 position 2022/23	Target year end (Mar 23)	Target Met
1. Treat the patient, treat the person	Care	SR1	Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation	Partial	Partial	Extreme 16	Extreme 16	High 12	-
	Care	SR2	We are unable to provide outstanding care as a result of weaknesses in our clinical governance	Good	Good	Moderate 8	Moderate 8	Moderate 8	-
2. Right care, right place, right time	Care	SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives	Partial	Partial	Extreme 20	Extreme 20	Extreme 16	-
	Collaboration	SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London	Good	Good	High 12	High 12	Moderate 8	-
3. Balance the books, invest in our future	Collaboration	SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities	Partial	Limited ⇩	Extreme 20	Extreme 25 ⇧	Extreme 16	-
	Collaboration	SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds	Partial	Partial	Extreme 20	Extreme 20	Extreme 16	-
4. Build a better St George's	Care	SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure	Good	Good	Extreme 16	Extreme 16	Extreme 16	-
5. Champion team St George's	Culture	SR8	We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best	Good	Good	Extreme 16	Extreme 16	High 12	-
	Culture	SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels	Partial	Good	Extreme 16	Extreme 16	High 12	-
6. Develop tomorrow's treatments today	Collaboration	SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation.	Good	Good	Moderate 9	Moderate 9	Low 6	-

Strategic Objective 1: Treat the Patient, Treat the Person
Strategic Risks SR1 and SR2

SR1:
Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality and learning across the organisation

SR2:
We are unable to provide outstanding care as a result of weaknesses in our clinical governance



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Strategic Objective	**Treat the patient, treat the person**		***Corporate Objective 2021/22:***	***Care***
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**			
Risk Appetite / Tolerance	**LOW**	Patient safety is our highest priority and we have a **low appetite** for risks that impact on patient safety. Our appetite for risks affecting patient experience is also low, but is higher than for risks impacting on patient safety. If patient experience conflicts with patient safety, the safety of services will always be our highest priority.		

Assurance Committee	**Quality Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Group Chief Nurse & DIPC Group Chief Medical Officer
Date last Reviewed	23 June 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR1 of 16 continues to reflect the level of risk around patient and staff exposure to the SARS-CoV-2 virus and delays in patient treatment and the elective backlog due to Covid-19.

Assurance rating:
An assurance rating of partial is proposed. The assurance rating reflects the fact that there are three actions identified to increase assurance which are not yet completed. There also continue to be unknowns related to the development of the pandemic, and controls the Trust can put in place either individually or together with partners can only go some way to addressing the risks associated with Covid-19.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating.

Gaps in control and assurance addressed year-to-date:
The Trust has successfully appointed to all new posts as recommended by the Clinical Governance Improvement Program. Progress has also been made to address the non-compliance with 7 day clinical standards. Directorates have defined plans in place to address all non-compliance. Capital works to install 2 static MRIs has commenced, expected to go-live in the Spring time of 2022. Progress has also been made with the development of electronic reporting for treatment escalation plans at divisional level. However, there has been slippage on the development of the ability to see this information at ward level which is now expected in July 2022. This will support the implementation of the Quality and Safety strategy

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score 2022/23
Q1	16 (4c x 4l)	Partial		20 = 4(C) x 5(L)	12 = 4(c) x 3(l)
Q2					
Q3					
Q4					

Emerging risks

- Culture shift to embed quality improvement does not happen, or does not happen quickly enough
- System working related to hospital specific clinical pathways may mean we cannot manage our own activity
- Quality Improvement Academy does not have traction to effectively promote a culture of learning across the Trust
- Impact of any future surge of Covid-19 on the Trust's ability to provide care to all patients in a timely way

Future opportunities

- We can utilise the data we hold related to our patients and the activity across our services to improve our learning in the organisation and how we plan and/ or deliver our services.
- We can also develop, adopt and promote key safety measurement principles and use culture metrics to better understand how safe our care is
- The new National Patient Safety Incident Reporting Framework with its enhanced focus on learning will enable us to work together with our patients and their families to improve our investigation of incidents
- Covid-19 provides opportunities to think differently about how we engage with patients, service users and their families

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Quality and Safety Strategy in place and approved by the Trust Board (January 2020) supported by an implementation plan	S				• Trust removed from Quality Special Measures in March 2020 following improvements documented in CQC inspection report published in Dec 2019 • Quarterly update reports to QSC re delivery against Quality and Safety Strategy year 2 implementation plan		X X	X
Serious Incident reporting and Investigation Policy including electronic incident reporting system (Datix) in place	S				• Weekly review of serious incidents at serious incident declaration meeting and monthly report to PSQG and QSC (Note the Trust is currently awaiting the new -Patient Safety Incident Reporting Framework) • Internal Audit report/internal management action plan: rated substantial assurance		X X	X X
Complaints Policy in place	G				• Quarterly complaints report to Patient Safety Quality Group identifying emerging themes and learning • Internal Audit report including internal management action plan: rated reasonable assurance • Learning from complaints included in divisional governance reports		X X X	X
Friends and Family Test – *SMS feedback method in place for virtual and face to face outpatient appointments* - Text messaging – SMS surveys for inpatient surveys setup. Ward display of FFT report 'You siad, we did'.	G				• Friends and Family Test: Monthly performance reports to QSC via IQPR		X	X
Infection Control Policy including Root Cause Analysis (RCA) for all C. Diff cases to ensure learning in place	S				• Infection control audit reports identifying emerging themes and improvement actions • Ward round monitoring to ascertain that infection control requirements are in place and followed and periods of increased Surveillance and Assessment (PISA)	X X	X X	
Early Warning Score training in place	G				• nEWS assurance audit	X	X	
Treatment Escalation Plans in place for all non-elective adult patients within 24 hours of admission	R				• Report to PSQG,		X	
Sepsis tool live on iClip	R				• Sepsis tool on iClip in place	X		
COVID-19 measures: patient testing, masks, and facilities	G				• Covid testing carried out on day 0, 3 and 7 of admission; Masks wearing for in-patients; Emergency floor development increased number of single isolation facilities • Daily compliance performance report for PCR testing	XX		
Governance structure – new positions all recruited to	G					X		
Life support training - Programme to increase the numbers of staff who have undertaken required life support training is in place	R				• March 2022 BLS 81.5%, ALS 76.2% and ILS 67.7%,	XX		

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards (also see SR3)	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Capital works to install 2 static MRIs has commenced, with the equipment was expected to go-live in January 2022, however it has now been deferred to Summer 2022. Budget setting and job planning for 2022/23 will address a number of gaps in 7 day services.	~~Feb 2022~~ May 2022	
Early Warning Score electronic devices not reliable due to IT issues as patient observations are not visible by the bedside. Lack of handheld devices to facilitate nurses' awareness of vital signs	**Improve Early Warning Score electronic device availability in the wards through Wi-Fi and address cold spot** *Wi-Fi will be addressed through the ICT Network improvement Project which is expected to run until the end of 2022*	~~Dec 2021~~ Dec 2022	
Appropriate level of training for Resus	Implementation of training needs analysis to support RNs undertaking BLS training instead of ILS TNA has just been approved at DMB level – to be presented at PSQG. Following approval, MAST team to implement the changes on the ARIS system	Sep 2022	

Strategic Objective	**Treat the patient, treat the person**		***Corporate Objectives 2021/22:***	***Care***
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			
Risk Appetite / Tolerance	**LOW**	We have a **low appetite** for risks that affect the robustness of our clinical governance structures, systems and processes as these can impact directly on the quality of care patients receive.	**Assurance Committee**	**Quality Committee**
			Executive Group	Patient Safety and Quality Group
			Executive Lead(s)	Group Chief Nurse & DIPC Group Chief Medical Officer
			Date last Reviewed	23 June 2022

Current risk and assurance assessment	**Overall SR Rating – Quarterly Scores**	**Period 2022/ 2023**	**Risk Score**	**Assurance Strength**	**Change** (last reporting period)	**Inherent Risk Score**	**Target Risk Score 2022/23**
Risk score: A change to the risk score for SR2 from 12 to 8 was agreed at the March Quality and Safety Committee meeting. The new risk score reflects the progress made in implementing the clinical governance improvement plan. No further changes are proposed to the risk score at this stage. Reducing the risk score further will be challenging given the inherent complexity of the services provided by the Trust. **Assurance rating:** The assurance rating of good was agreed at the March Quality and Safety Committee meeting. This is on the basis of progress achieved in implementing the clinical governance improvement plan. **Changes since last quarter:** Risk score: A reduction in the risk score from 12 to 8 Assurance rating: Improvement from partial to good **Gaps in control and assurance addressed year-to-date:** There has been significant progress against the Clinical Governance Improvement programme. There are two outstanding actions from the phase 1 and 2 clinical governance reviews which will be taken forward under the remit of the Mortality Monitoring Group and three outstanding actions from the phase 3 review which require further work following the establishment of the St George's, Epsom and St Helier University Hospitals and Health Group which will be completed in Q1 2022/23. There are 5 further gaps in control where action is being taken		Q1	**8 (4c x 2l)**	**Good**		**20 = 4(C) x 5(L)**	**8 = 4(C) x 2(L)**
		Q2					
		Q3					
		Q4					

Emerging risks	**Future opportunities**
• Impact of any further Covid-19 waves • Impact of operational pressures on clinical governance meetings	• IT developments to support new ways of working e.g. care group meetings and communication

Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Action plan to deliver improvements identified by the CQC	S				• CQC action plan close report to QSC in May 2021 • One should do action remained open and monitored on an exception basis in PSQG (measures to avoid mixed sex breaches in children's services). Close report approved at PSQG in September 2021 and all actions completed	X	X	X X X
Board agreement to invest in identified improvements to clinical governance	S				• Phase 1 and phase 2 external governance reviews • Phase 3 report and Board approved analysis of outstanding recommendations • Actions from the external governance reviews integrated into the year 2 implementation plan for the Quality and Safety Strategy with quarterly updates reports to QSC		X	X X
Improvement plan for Cardiac Surgery services	S				• Independent external mortality review • CQC inspection report December 2019: recognised improvements in Cardiac Surgery governance processes • NICOR: The Trust is out of alert and is within the expected mortality range	X	X	X X X
Risk management framework in place	R				• CQC inspection report December 2019: negative references to documentation of risks on risk registers • Internal audit report 2021 gives reasonable assurance		X X	X X
Mental Capacity Act (MCA) and Depravation of Liberty Standards strategy in place	S				• MCA Steering Group reports to PSQG demonstrating progress against MCA strategy. MCA Steering Group to be re-launched in October 2021 due to changes in leadership		XX	
MCA level 1 and level 2 training programme in place	R				• MCA level 1 and 2 training levels across all staff groups reported	X X	X X	
Electronic templates for the recording of Capacity Assessment and best interest decisions	G				• Electronic templates for the recording of Capacity Assessment launched on 2 November 2020	X		
Medical Examiner System in place	S				• Medical Examiner office reviewed all non-coronial inpatient deaths in May 2020		X	X
Mortality Monitoring Committee and Learning from Deaths lead in place	G				• Learning from Deaths report including SHMI and sources of individual mortality alerts e.g. NICOR		X	
eDischarge summary live on iClip	R				• Trust does not comply with NHSE Standard Contract for Discharge Summary.	X		X
Governance structure – new appointed recruited to	R					X		
Agreed methodology for Consent and Trust lead in place	R				• Bi-annual Consent audit included in Audit Committee agreed Clinical Audit Programme 2021/22	X	X	

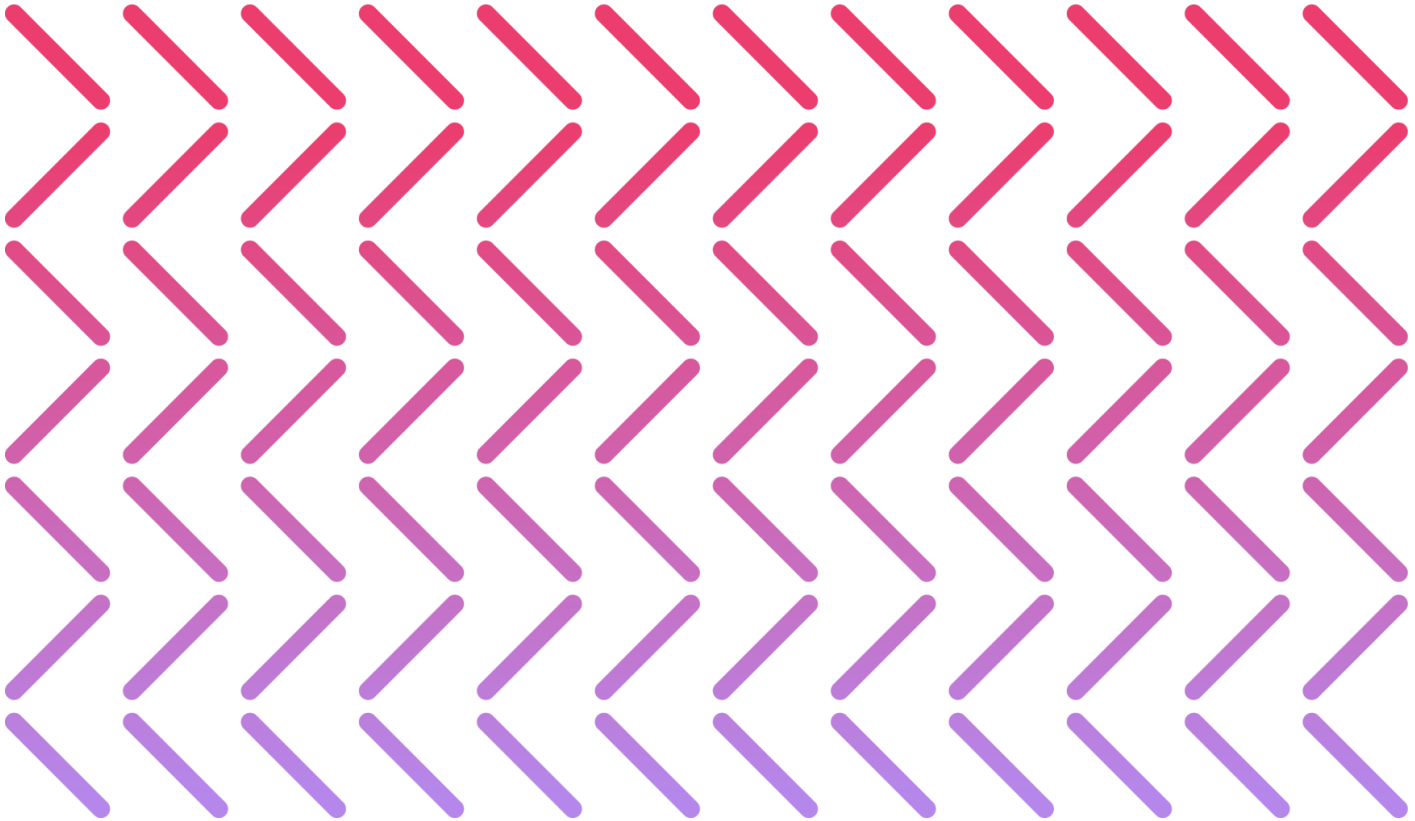
Strategic Objective	Treat the patient, treat the person	*Corporate Objectives 2021/22:*	*Care*
SR2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Areas for improvement identified by the three phases of the external clinical governance review	Delivery of the Clinical Governance Improvement Programme 2021/22, which incorporates all agreed recommendations from the three phases of the external clinical governance review. Latest update to QSC provided to the Mach 2022 QSC with the recommendation of the formal closure of the clinical governance improvement plan – not withstanding the remaining outstanding actions and their progress to completion.	Closed	
Full implementation of the Cardiac Surgery action plan to address all recommendations from the reviews	**Implement the Cardiac Surgery action plan** One remaining action left to be completed regarding medical staffing within CTICU out of hours, due to covid-19 pandemic this has not yet been addressed.	~~Oct 2021~~ Jun 2022	
MCA level 3 training module	**Develop and implement MCA level 3 training module. Level 3 / Champions programme** *The development of a level 3 MCA training programme has been paused. The programme will be developed as part of the preparation for the implementation of the Liberty Protection Safeguards.*	~~April 2022~~ Sep 2022	
OrderComms catalogue not kept up to date therefore not all results are reported via Cerner	**Update Cerner OrderComms catalogue:** *Delayed as resources diverted to set up COVID vaccine hub* The SWLP LIMS project is working through each discipline in terms of order comms and completing end to end testing of the orders between Clinisys WinPath Enterprise and all of the order comms systems in the sector including SGH's iCLIP. Due to the complexities and multiple stakeholders of SWLP the completion date has been moved to Jun 2022	~~Dec 2021~~ Jun 2022	
eDischarge Summary Form not available on iClip	**Finalise the eDischarge form to be included onto iClip:** The discharge MPage workflow went live within iClip during February 2022. This includes sections to be completed for different elements of the patients' clinical care, which contribute to the end production of the discharge summary. This has been adopted as standard, and ongoing support is available to embed the process.	Closed	
Liberty Protection Safeguards (LPS) process not yet issued by DoH	*Trust to implement LPS from April 2022 following DoH guidance. Consultation started in April 2022*	Sep 2022	

Strategic Objective 2: Right Care, Right Place, Right Time
Strategic Risks SR3 and SR4

SR3:
Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

SR4:
As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London



Outstanding care every time

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care

SR3	Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that impact on operational performance as this can impact on patient safety, but our appetite here is higher than for risks that directly affect the safety of our services

Assurance Committee	**Finance Committee**
Executive Lead(s)	Managing Director – St George's; Group Chief Finance Officer
Date last Reviewed	24 June 2022

Current risk and assurance assessment

Risk score:
It is proposed that a risk score of 20 continues to reflect the level of risk in relation to both access to treatment and ICT.

Assurance rating:
Proposal for the assurance rating to be improved from Limited to Partial was agreed at the Finance and Investment Committee in January 2022

Changes since last quarter:
The calculation of the risk score was changed at Q4 2021/22 from 5c x 4l to 4c x 5l. No changes to the risk score are proposed in Q1 2022/23.

Assurance rating: It is proposed that the assurance rating remains unchanged at 'Partial'. Whilst the grip, monitoring and assurance on mitigations is now 'good' for both operational delivery and IT, overall the Trust does not meet the standard outlined on slide 18 defining 'good' because performance does not meet one element of the assurance criteria, namely "Outcomes are generally achieved but with inconsistencies in some areas". In essence the control of the risks are good, but their impact is not completely mitigated hence remaining at 'Partial' assurance

Gaps in control and assurance addressed year-to-date:
The Trust has continued to demonstrate consistent delivery for Priority 1 patients (cancer and non-cancer, treat within 72 hours) and Priority 2 patients (cancer and non-cancer, treat within 28 days). This means that we are treating patients with urgent clinical needs in a timely way.

The Flow Improvement Programme has commenced, with specific QI actions regarding RedtoGreen, morning discharges, timely completion of D2A referrals.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	20 (4c x 5l)	Partial	⟷	25 = 5(C) x 5(L)	
Q2					
Q3					
Q4					

Emerging threats

The combination of increased patient acuity, ineffective speciality pathways caused by COVID wards (COVID and non-COVID patients) making patient flow slower; together with challenges in onward capacity in care homes / nursing homes means that there has been a fundamental mismatch between admission rates / length of stay and discharge rates on medical non-elective inpatient pathways, with significant deleterious impact on flow through the ED. This has caused 12 hour breaches for patients awaiting an inpatient bed and, on occasion, 60+ minute ambulance handover breaches, although George's continues to perform at or above average for the latter when compared against other London Trusts. Although performance for breast screening has returned to normal levels, a combination of staff sickness / pathway under-performance and ongoing increased referrals means that the TWR performance for breast has deteriorated further. Additional resourcing has been secured from January to address this, together with a number of operational actions to improve pathway management.

Future opportunities

The Trust continues to implement QI projects to optimise flow, and is supporting our community health partner in the implementation of a sub-acute Hospital@Home model, which takes patients home for treatment and care once the patient has been assessed, diagnosed and a treatment plan implemented by AMU. There is system commitment to expand and develop this service to minimise avoidable admissions for people with frailty / long term conditions if they can be cared for at home through this collaborative pathway, in line with the 2022/23 Operating Plan. There are also actions ongoing to expand the capacity and resilience of medical and surgical Same Day Emergency Care pathways (SDEC) which divert patients away from ED to speciality 'hot' clinics that can best meet their need and minimise numbers in ED.

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of assurance (positive/ negative)		
	Q1	Q2	Q3	Q4		1	2	3
Clinical Safety Strategy	S				Clinically driven plan agreed at Operational Management Group and approved at Quality and Safety Committee		X	
Insourced company to manage adult and paediatric ECHO.	P				Performance included in Integrated Quality and Performance Report (IQPR)	X	X	
Digital strategy - ICT Work plan aligned to Digital strategy	R				Digital strategy aligned to clinical strategy and outpatient strategy			XX
VDI	S				VDI project updates to IGG – project has completed	X	X	
Virtual clinics – video conferencing system with patients (Attend Anywhere) in use with supporting laptops, webcams and headsets installed; operational management by Corp OPD	R				Informatics Governance Group		X	
New workflow in iClip for Referral Assessment Service (RAS) clinics as part of Covid19 changes and rolled out to Trust as BAU	S				ICT Outpatient Project Steering Group and the Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of iCLIP clinic documentation for physical or virtual OPA available.	S				Trust Communications news story published in Staff Bulletin 26 June 2020	X		
Provision of Office365 and Microsoft Teams to support MDT cancer and orthopaedic meetings and further roll out in progress	S				ICT Covid-19 Service Management Report presented to IGG in April 2020 10,000 staff migrated to Office 365 with access to teams presented to IGG Oct 2020		X X	
ED rapid assessment and triage process in place	S				Clinical pathway and Standard Operating Procedure (SOP)	X		
Direct access pathways	S				Clinical Pathway and SOP	X		
Partnership working between ED and local Mental Health organisations to improve care and waiting time for patients attending the ED with mental health needs	R				Clinical Pathway, Memorandum of Understanding/ COMPACT, and local service performance metrics	X		
UCC direct pathways	S				Clinical Pathway and SOP	X		
Clinical Decision Outcome Form (CDOF) incorporated within iClip	P				eCDOF Tableau report showing operational non-compliance	XX		

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Seven day clinical services standards	**Implementation of Divisional action plans to achieve seven day clinical service standards compliance.** All Care Groups have updated their risk assessment. Directorates have defined plans to address all non- compliance. Capital works to install 2 static MRIs has commenced, with the equipment to go live in August 2022. Budget setting and job planning for 2021/22 will address a number of gaps in 7 day services.	Aug 2022	
Cyber security	Implement recommendation to improve cyber security - 2020/21 Project Plan – completed after penetration test. The network is segmented via VLAN, migration from N3 to HSCN done, password policy implemented. Forcepoint and IPS in place. Cyber Essentials Plus task and finish group underway to provide assurance for end December 2021. It is envisaged that this will not meet the standards as Agresso not updated until April 2022. Q4 update= CE+ assessment is being updated so during 22/23 the trust will evaluate the changes prior to seeking accreditation so due date modified	Oct 2022	
ICT disaster recovery (DR) plan – require solution for 2nd data centre	Design ICT disaster recovery (DR) plan to include provision for second data centre Draft plan for hybrid model approved by IGG in Dec 2020; Site for a 2nd physical onsite data centre will be longer term depending on internal build such a renal unit, or availability in community or sites in SW London. Cloud solution for partial DR now purchased and being configured. Current phase is implementation, moving suitable systems across to cloud solution with view to reducing score when complete so due date modified but awaiting high speed VPN - delays due to resourcing constraints but new ICT Head and Deputy Head of Infrastructure now in post to complete the work. Funding yet to be secured during 22/23 for the second data centre	~~Mar 2021~~ Oct 2022	
MDT teleconferencing for SWLP, equipment not yet provisioned; workflows changed due to Covid-19	ICT Project Plan 2020/21 to improve hardware and workflow for MDT teleconferencing. 4 rooms out of the original requirement for 6 rooms have been delivered. Delay completing as 2 further rooms need to be identified by organisation. Surveys completed for remaining 2 rooms but one is awaiting PFI estates work in AMW, and 6th identified room in DSU has been taken over for another project so a new site survey for alternative 6th room in ENT seminar room now to be arranged. Due date updated for end calendar year	~~Sep 2020~~ ~~Sep 2021~~ ~~Dec 2021~~ ~~Apr 2022~~ Dec 2022	
Data warehouse capacity - not built to deal with current volume of data / continue use of paper based records. Cerner nightly extracts being terminated.	Project to improve data warehouse in capital plan 20/21 delayed due to Covid and now in 21/22 plan. Improvement project identifying alternative models of data management, with requirements developed to consider other organisations in SW London. Detailed project plan but not scheduled to complete until Nov 2022	~~Mar 2021~~ ~~Apr 2022~~ Nov 2022	
Multiple clinical systems which do not interoperate leading to fragmented clinical records (use of standalone systems not using patient MRN as single identifier)	Anaesthesia project to roll out Anaesthesia Module and retire paper charts during 2022 Funding secured for upgrade of Viewpoint and integration to iCLIP during 2022/23 and to replace the current maternity solution with iCLIP maternity solution which will be a 1year project. The risk will decrease after maternity project completes Funding to be secured for integration projects of smaller standalone systems e.g. Auditbase and Optimum	~~Dec 2020~~ ~~Dec 2021~~ ~~Sept 2022~~ Sept 2023	
ICT network infrastructure is old and not sufficiently resilient or able to meet today's demands for Wi-Fi and video-conferencing	Replacement of network core completed in Q2; additional requirements to implement DMZ being resourced; followed by campus network and Wi-Fi completing Q4 2022/23. Phased improvement over this time period.	~~Mar 2022~~ Dec 2022	

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2020/21:*	Care
SR3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Single view across all patient G&A flow	**Steps to be taken at individual ward level to get ownership and feedback loop in place on key metrics of flow:** • Consistent use of Red to Green to aid discharge planning • Benchmarking on length of stay and feedback loop by clinical speciality • Consistent volume of pre-11am discharges	Dec 2022	
Cerner resource to implement Digital Bed Management Tool in iClip	Identify Cerner resource to implement Digital Bed Management Tool in iClip	TBC	-
Emergency Department capacity	Expand sub-acute Hospital@Home to take patients home from ED / AMU (once worked up), avoiding inpatient admission where this additional resource prevents need for acute admission	TBC	-

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Collaboration

SR4	As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London

Risk Appetite / Tolerance

MODERATE

Because we recognise that significant changes are necessary across the South West London system, we have a moderate appetite for risks that impact on system transformation and cross-system working in order to facilitate changes that will improve care for patients across South West London.

Assurance Committee	**Trust Board**
Executive Lead(s)	Group Chief Executive Officer
Date last Reviewed	5 May 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR4 of 12 continues to reflect the significance and importance of system working, and attendant risks.

Assurance rating:
The Board increased its assurance rating for SR4 from "partial" to "good" at Q4 2020/21, and a continuation of this position is proposed.

Changes since last quarter:
No changes to risk scores or assurance ratings are proposed at Q1 2022/23.

Gaps in control and assurance addressed year-to-date:
This risk has been mitigated by the establishment of new controls :

- The opening of the new modular surgery unit at Queen Mary Hospital as a centre for elective surgery which will assist the Trust and the wider SWL system reduce the elective backlog.
- The appointment of the Trust Chief Executive as Lead CEO for the SWL Acute Provider Collaborative
- Establishment of the St George's, Epsom and St Helier Hospital Group, including:
  - A single Executive team in place from 1 February
  - MoU and Information Sharing arrangements developed
  - Group governance arrangements developed
  - Appointments to key roles at Group and Site level made
  - Strengthened arrangements across Group for engagement at Place and with ICS
- Passage of Health and Care Act 2022 provides greater clarity about future system working arrangements.
- Executive Director appointments made to SWL ICB which has taken on statutory form from 1 July 2022.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 21/22
Q1	High 12= 4(C)x3(L)	Good	⟷	16 = 4(C) x 4(L)	8 = 4(C)x2(L)
Q2					
Q3					
Q4					

Emerging risks

- The continued focus on the response to Covid-19 may put additional pressure on the clinical and management capacity within the Trust to focus on collaborating with system partners to transform services.
- System-wide financial pressures impacting on transformation opportunities

Future opportunities

- The development of the ICS into a statutory organisation may support closed system working and provide a statutory framework on which to build closer collaboration and integration.
- The Group model between the Trust and Epsom St Helier will offer opportunities to transform and integrate services between the two trusts.
- Epsom St Helier's Building Your Future Hospitals programme may provide an opportunity for greater collaboration between St George's, Epsom and St Helier and the Royal Marsden

Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22:*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
The SWL ICS Programme Board on which the Trust CEO is a member	R				• CEO representation on the Board • Quarterly SWL ICS Updates to Trust Board		X	X
The Trust is a member of the SWL Acute Provider Collaborative	S				• The APC is chaired by the Trust CEO		X	X
SWL Covid-19 Recovery Structure has been established	R				• Trust representation on key workstreams • CEO is a member of the Recovery Board and chair of the Elective Recovery Programme		X	X
SWL Clinical Senate - set the clinical priorities for SWL	R				• The Trust is represented on the Clinical Senate by the CMO		X	X
SWL ICS Five Year Plan - the Trust contributed to developing the five year plan which set the priorities for SWL	R				• The Trust is represented at all SWL Integrated Care System meetings • The SWL ICS and Acute Provider Collaborative Forums allow general oversight of commissioner and provider plans to develop relationships outside the sector • The Trust is an active contributor to the key 'enabling' workstreams across the SWL ICS e.g. Workforce, Digital, Finance		X	X
SWL Covid-19 Recovery Plan - driving greater collaboration	R				• The Trust CEO is a member of the SWL ICS Covid-19 Recovery Board , Steering Group and is chair of the Acute Cell		X	X
The Trust Workforce Strategy approved by Trust Board in November 2019 – a key driver being delivery of the SWL five year plan as well as the Trust's clinical strategy	R				• Implementation plans are in place and being delivered against		X	
Annual review of Trust Strategy	S				• The review of Trust strategy undertook in June confirmed that the priorities are still relevant taking account the changes in the external environment.		X	
Trust contribution to the Wandsworth and Merton Local Health and Care Plans	R				• The Trust is represented on this Board and an active contributor to both of the Borough Health and Care Partnership Boards		X	X
Development of Group model to pursue closer collaboration between St George's and Epsom and St Heliers Hospitals	S				• Group model agreed and being implemented		X	

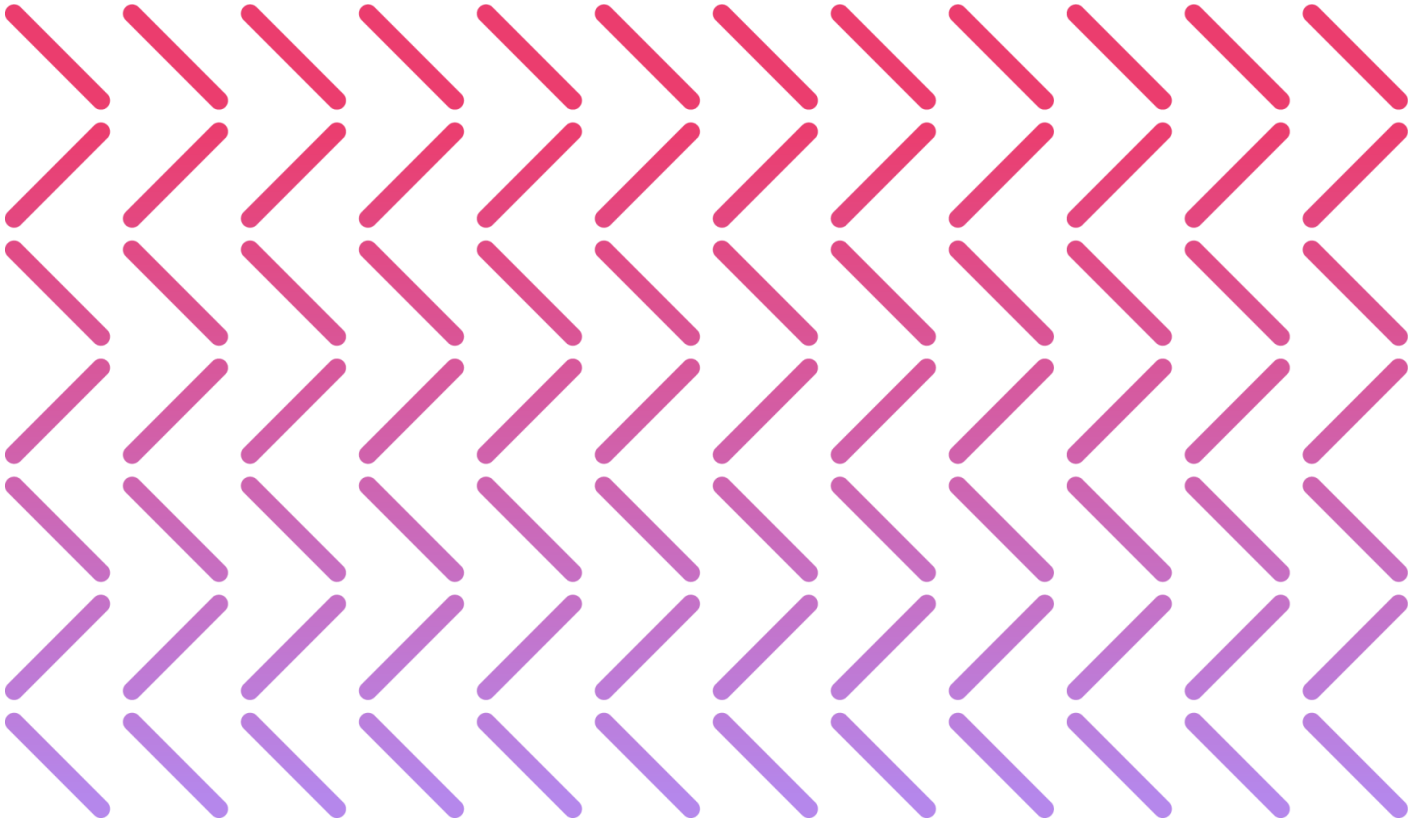
Strategic Objective	Right care, right place, right time	*Corporate Objectives 2021/22*	Collaboration
SR4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Limited clinical and management capacity within the Trust to engage with and deliver the clinical priorities for Wandsworth and Merton as set out in their respective Local Health and Care Plans	Both Wandsworth and Merton Health and Care Partnership Boards are reviewing the priorities in the LCHPs in light of Covid-19 and changes to the ICS structure, and this will provide an opportunity to re-assess the Trust's role in delivering these (The Trust is represented on both Boards) Future business planning activities to take account of the Trust's contribution to delivering the key priorities in the LHCP. This action was originally envisaged as part of planning for 2021/22, but due to COVID-related disruption to the NHS planning cycle in that year will be addressed in 2022/23.	~~March 2021~~ Mar 2023	
Impact of specialised commissioning devolution on the Trust's clinical service income	Engagement with the SWL system to shape arrangements for spec com devolution in SWL.	Jun 2022	

Strategic Objective 3: Balance the books, invest in our future
Strategic Risks SR5 and SR6

SR5:
We do not achieve financial sustainability due to under-delivery of cost improvement plans and failure to realise wider efficiency opportunities

SR6:
We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds



Strategic Objective	**Balance the books, invest in our future**								
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**								
Risk Appetite / Tolerance	**LOW**	We have a low appetite for risks that will threaten the Trust's ability to deliver services within our financial resources	**Assurance Committee**	**Finance Committee**					
			Executive Lead(s)	Group Chief Finance Officer					
			Date last Reviewed	24 June 2022					
Current risk and assurance assessment	**Risk score:** The Trusts financial plan is currently breakeven. However, with the overall scale of the CIP needed to reach breakeven, the material level of unidentified CIP and the fact we are at the end of June there is considerable uncertainty that the plan can be delivered. The lack of visibility of a clear path to breakeven and the level of concern within the Executive Group and discussions at the Finance Committee it is proposed to score this risk as 25; at this time it is certain the Trust will fail to achieve breakeven, a likelihood score of 5, and the impact is above the threshold to score a 5. **Assurance rating:** In the context of the scale of the financial challenge, the material level of unidentified CIP, and that at end Q1 2022/23 there is considerable uncertainty as to whether the plan can be delivered, the Finance Committee agreed to lower the assurance rating for SR5 from 'partial' to 'limited'. **Changes since last quarter:** • Increase in risk score from 20 to 25 • Decrease in assurance rating from 'partial' to 'limited'.		**Overall SR Rating – Quarterly Scores**	**Period 2021/ 2022**	**Risk Score**	**Assurance Strength**	**Change (last reporting period)**	**Inherent Risk Score**	**Target Risk Score**
				Q1	**Extreme 25 =5(c) x 5(L)**	**Limited Assurance**	↑ Risk increased: 20 to 25 ↓ Assurance lowered from partial to limited	**25= 5(c) x 5(L)**	**16 = 4(c) x 4(L)**
				Q2					
				Q3					
				Q4					
			Emerging risks			**Future opportunities**			
			• Scale of CIP to deliver • Risk as to whether the Trust can deliver 104% of value weighted activity • Budgetary control – restoring good practices post-Covid • Controlling run rates in the post-Covid environment			• Financial improvement/mitigation through further collaboration within the SWL ICS and the Group • New financial system • Enhance financial accountability			

Strategic Objective	Balance the books, invest in our future
SR5	**We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities**

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly divisional finance meetings with in place with DCFO to discuss areas for escalation (underspends/overspends)	S				Monthly divisional finance reports	x	X	
Monthly reporting of financial issues through to OMG, TMG, GEM, FC and Board	S				Monthly Trust finance reports	x	x	
Monthly external review of Trust position by NHSE as part of monthly top-up payment review	S				Top up payment made to Trust		x	x
Financial plan for 2022/23 submitted, with monthly performance being scrutinised vs budget	P				Monthly report to Finance and Investment Committee		x	
South West London FAC continued to develop system financial management processes in support of delivery of control totals.	S				SWL Monthly Finance Report			x

Strategic Objective	Balance the books, invest in our future
SR5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Plan for 22/23 submitted, but material financial risks to delivery	- Development and implementation of full CIP for 2022/23	End Sept 2022	
Scale of unidentified elements within CIP for 2022/23	- 44% of target CIP remains unidentified, which is phased in the back end of the year. Completion of process to identify remaining areas within CIP programme	End Sept 2022	
Need for strengthened oversight of turnaround at Group and Site levels	- Fully establish financial turnaround governance arrangements	July 2022	
Lack of accountability within services for financial performance and delivery	- Ongoing operational challenges have delayed the implementation of this mitigation. - Finance to be included within objectives of all leadership posts with financial responsibility within the organisation - Turnaround governance arrangements	End Sept 2022	
Leveraging system benefits within SWL	- Planning and sustainability group in place and plans being developed (dates yet to be confirmed)	TBC	
Budgetary control	- Establish clear control / support environment with budget holders	TBC	

Strategic Objective	Balance the books, invest in our future
SR6	**We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds**

Risk Appetite / Tolerance	**LOW**	Due to the importance of securing investment in the Trust's ageing estates infrastructure, we have a low appetite for risks that could impact on the availability of capital	**Assurance Committee**	**Finance Committee**
			Executive Lead(s)	Group Chief Finance Officer
			Date last Reviewed	24 June 2022

Current risk and assurance assessment

Risk score:
The current risk score of 20 (4c x 5l) was endorsed by the Finance Committee on 24 June 2022, the same as at Q4 2021/22.

Whilst the Trust currently has a capital plan that remains within allocations for 22/23, there are significant number of risks that are unaffordable within the current allocation. In addition, there are many schemes and projects required to be delivered within the year 2 to 5 plan that are currently unaffordable within allocations within SWL. It is unlikely that the Trust will be able to undertake all the investments it would like over the next 5 years, however, the trust will have access to significant sums of capital meaning that it will be possible to address critical issues.

Assurance rating:
The Finance and Investment Committee endorsed a continuing assurance rating of "partial" at its meeting on 24 June 2022.

Changes since last quarter:
No changes in risk score or assurance rating at Q1 2022/23.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score
Q1	20 4(c) x 5(l)	Partial	⟷	20 = 4(c) x 5(L)	16 = 4(c) x 4(l)
Q2					
Q3					
Q4					

Emerging risks

- Trust awaiting confirmation of year 2 funding for the TIF ITU expansion programme.
- Funding relating to the Trusts key strategic priorities, and the estates strategy is still to be confirmed for 22/23 and beyond. It is unlikely the Trust will be able to undertake all the investments it would like over the next 5 years, however the trust will have access to significant sums of capital meaning that it will be possible to address critical issues.
- Inflation: Current inflationary pressures could increase the cost of projects making it difficult to complete all schemes planned within available funds.

Future opportunities

- Further prioritisation within SWL to move money to address material and urgent risk at St George's.
- Further funding likely to be made available to bit from NHSE.

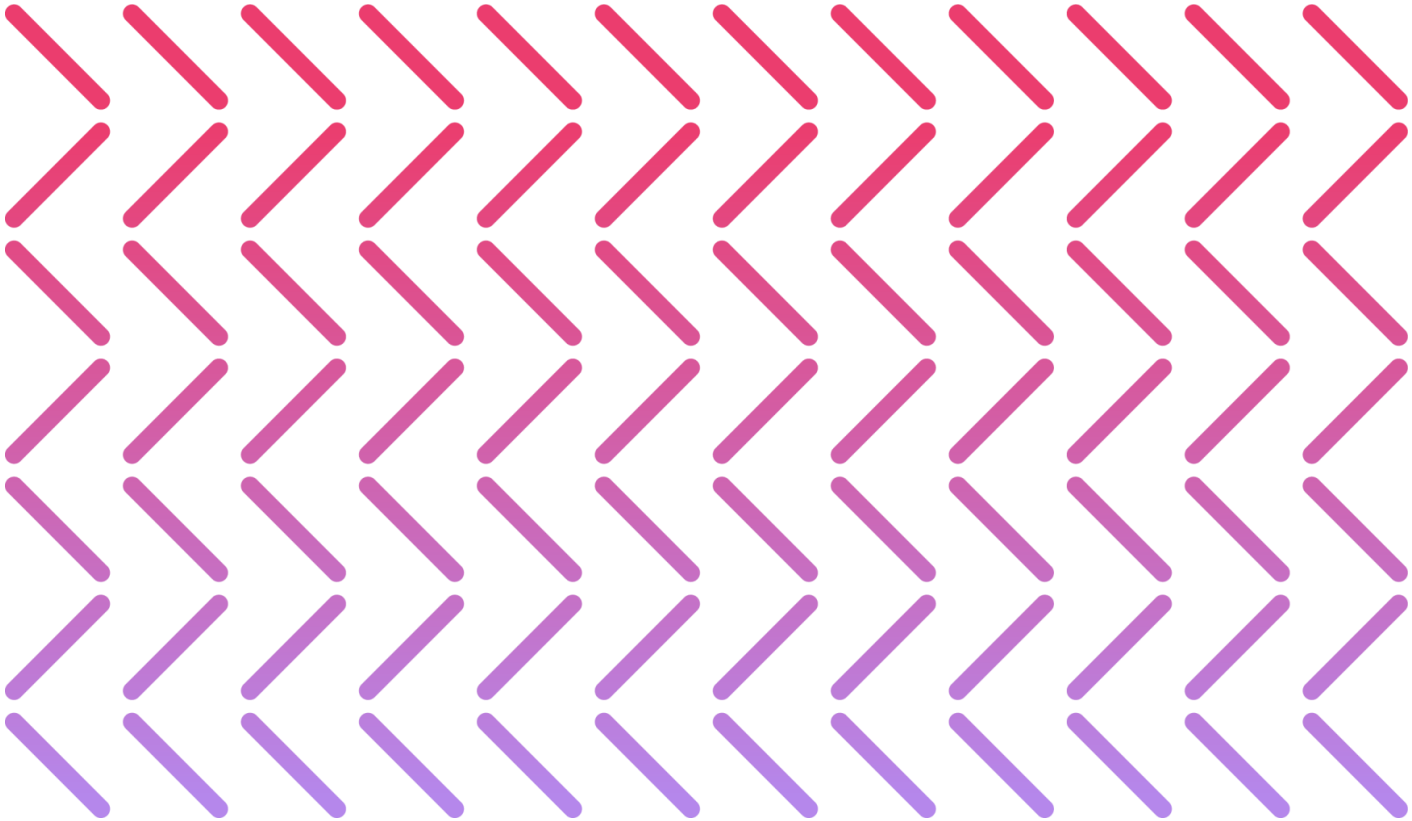
Strategic Objective	Balance the books, invest in our future
SR6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Monthly reporting to FIC and Trust Board on key areas of risk, both financially, and due to non-investment.	S				Monthly finance reports		X	
Weekly Capital funding update and discussion, to review clinical urgency of requests.	S				Weekly update to OMG on status of COVID capital bids		X	
Evolution and development of capital prioritisation at SWL level through CFO meeting (FAC)	S				SWL Capital Plan report		X	
Plan for capital expenditure of £45.981m in place for 2022/23	R				Funding in place		X	X

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Confirmation of funding for 22/23 programme	Mitigation developed via Targeted Investment Fund bids – confirmation of year 2 TIF ITU expansion programme awaited	TBC	
Challenging capital position given scale of demand and impact of inflation	Careful monitoring and forecasting of capital required throughout the year	March 2023	
Prioritisation of 22/23 programme	To be kept a live issue to help manage risk	March 2023	

Strategic Objective 4: Build a better St George's
Strategic Risk SR7

SR7:
We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure



Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*

SR7	We are unable to provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure

Risk Appetite / Tolerance	LOW	We have a low appetite for risks that affect the safety of our patients and staff

Assurance Committee	**Finance Committee**
Executive Group	Trust Management Group
Executive Lead(s)	Managing Director – St George's
Date last Reviewed	24 June 2022

Current risk and assurance assessment

Risk score:
Based on the improving physical and control environment, the risk score is proposed to remain at 16. This follows the lowering of the score from 20 in Q4 2021/22.

Assurance rating:
Based on the independently verified assurance reports, it is proposed that the assurance rating remains as Good, following the increase in assurance rating from partial in Q4 2021/22.

Changes since last quarter:
No changes in Q1 2022/23.

Gaps in control and assurance addressed year-to-date:

- In terms of the physical environment, we have continued to invest capital to reduce our maintenance backlog, improve electrical, fire and water infrastructure whilst also improving the clinical service environment in key areas such as ED and cardiac catheter labs. New investments in the MRI and ITU buildings will come on line in the coming months.
- We have improved our internal processes on assurance together with revitalising our assurance reviews. This has been reflected by seeing good reports from our authorised engineers on fire and water assurance, both of which noted the continued process of improvement to both the physical environment and management systems.
- Moving forward, reducing the risk further will still require investment in infrastructure, particularly fire. This requirement is being collated into an overall capital programme, with a number of approaches to be detailed, in the work to develop our estate strategy into a strategic outline case.

Overall SR Rating – Quarterly Scores

Period 2021/ 2022	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	16 (4c x 4l)	Good	⟷	25 = 5(C) x 5(L)	12 = 4(c) x 3(l)
Q2					
Q3					
Q4					

Emerging risks

- Lack of long term capital availability affects ability to plan and deliver improvements
- Failure to secure HIP funding as first building block of estate strategy
- Relationship with University blocks future development of the site

Future opportunities

- Alternatives to HIP scheme being developed by estate strategy team
- Improving relationship with University may unlock future development opportunities
- Working with commercial partners to source alternative means of development / funding

Strategic Objective	Build a better St George's	*Corporate Objective 2021/22*	*Care*
SR7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)			
	Q1	Q2	Q3	Q4		1	2	3	4
Risk adjusted backlog maintenance programme informed by Authorised Engineer reports and independent condition surveys	S				The most recent independent reports have shown good levels of assurance Safety working groups are now all meeting again PAM now provides enhanced assurance, this has now been assessed externally and improvements being implemented.. CQC report 2019 - technical assurance has been provided on the key areas of concern where reactive maintenance could potentially impact patient care		X X X	X X X X	X X X X
Investment profile provides plans to manage backlog maintenance investment	W				Longer term capital planning is still a concern but is due to be addressed in the next financial year		X		
Governance systems in place to provide oversight on critical estates issues	P				The PAM has been submitted for 20-21 and actions are being monitored. Costed action plans need further development due to the changes with the Estates strategy.			X	
Estate Assurance Group to review all key assurance and activities	S				The Group is now meeting regularly to review key assurance activities		X X		X
Green Plan	S				A first Green Committee has been held and more detailed action planning is underway		X	X	
Estates Strategy	S				Estates strategy is now being developed into a Strategic Business Case which will provide further details on options and implementation		X		X

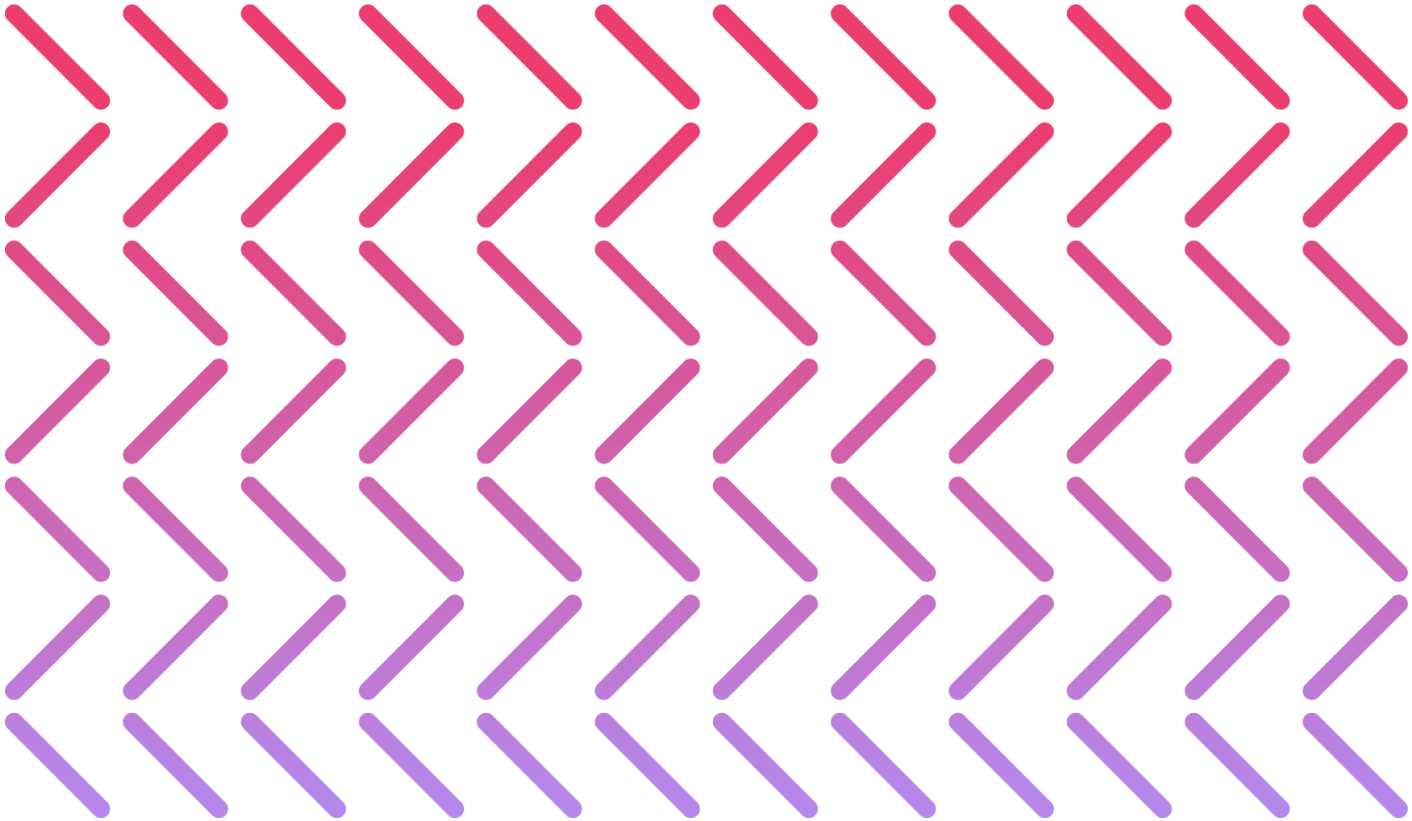
Strategic Objective	Build a better St George's	*Corporate Objectives 2021/22:*	Care
SR7	We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
No centralised data management system in place to ensure all required information is available and coordinated	We have a dedicated resource working on our data management system. We believe we have now found a suitable system, that was been developed jointly by Trusts in NW London and are looking to join their consortium to bring together our ERIC / PAM / Asset data into a single cloud database. We are developing a business case to deliver this and anticipate a first draft of this being available in Q1 22/23	~~Jan 2022~~ Jun 2022	
Estates restructure	This work has been delayed due to the need to respond to COVID pressures but is being prioritised over the coming months	~~Mar 2022~~ July 2022	

Strategic Objective 5: Champion Team St George's
Strategic Risks SR8 and SR9

SR8:
We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff do not feel safe to raise concerns and are not empowered to deliver to their best

SR 9:
We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels



Outstanding care every time

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity**		

Risk Appetite / Tolerance	**LOW**	Due to concerns around bullying and harassment and the ability of staff to speak up without fear, we have a low appetite for risks that could impact on the culture of the Trust	**Assurance Committee**	**People Committee**
			Exec Review Group	People Management Group
			Executive Lead(s)	Group Chief People Officer
			Date last Reviewed	10 June 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR8 of 16 reflects the level of risk in relation to culture across the organisation. The strengthening culture action plan has been developed and is now being implemented, which is monitored via the Culture Equity and Inclusion Programme Board on a monthly basis.

Assurance rating:
It is proposed that we maintain the assurance rating at Good for Q1 to reflect the progress the Trust has made in mitigating the risk but also the challenges the Trust still faces as shown in latest staff survey.

Changes since last quarter:
No changes compared with Q4 2021/22.

Gaps in control and assurance addressed to date:
During 2021/22 the risk has been mitigated by the completion of a number of identified gaps in controls:

- There is clear governance and reporting through the Culture, Equity and Inclusion Programme Board
- Successful recruitment to the OD team
- Staff Survey 2021 priorities developed into new Big 5
- Quarterly Pulse Survey implemented
- New IT system implemented for recording PDRs
- Management Fundamentals training outlined and due for design and implementation in May 2022
- Progress has been made in delivering the D&I action plan to date, which is now being implemented
- Staff Networks have been established with Terms and References and appointed Chairs

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	16 (4c x 4l)	Good	⟷	20 = 4(C) x 5(L)	12 = 4(c) x 3(l)
Q2					
Q3					
Q4					

Emerging risks

- Impact of operational pressure staff health and well-being.
- Pandemic and operational pressures led to the cancellation and / postponement of a range of training and development opportunities for staff, including management training
- Risk that culture programme does not deliver anticipated changes / improvements
- Length of time in resolving concerns raised via FTSU impacts on staff confidence in speaking up

Future opportunities

- Work to refresh the Trust's values
- Delivery of the culture change programme
- Learning from Trusts with positive FTSU cultures and from NHSE&I's ongoing support on FTSU.

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive /negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce strategy in place and approved by the Trust Board	S				Workforce Strategy refreshed and approved by Trust Board.		X	
Culture change programme established with clear timelines for delivery.	S				Culture plan reviewed and endorsed by the Trust Board. Delivery of plan overseen at Board level by the People Committee and on the management side by the Culture, Equity and Inclusion Programme Board and People Management Group		X	
Culture, Equity and Inclusion Programme Board established	S				CEI Programme Board meets monthly, chaired by the Group CEO	X	X	
The Diversity and Inclusion action plan agreed by the Trust Board	S				Progress of D&I action plan delivery reviewed at PMG and People Committee	X	X	
Trust D&I lead recruited and in place	S				D&I Lead in post.	X	X	
Staff networks in place to support particular groups	R				Networks in place and meeting regularly. Positive early engagement from staff in staff network groups. Network chairs in place, TORs agreed	X	X	
Big 5 launched in order to address issues raised by staff in NHS Staff Survey 2022	S				Detailed plans for each themed Big 5 month in place, and delivery overseen by CEI Programme Board, PMG and People Committee		X	
Freedom to Speak Up Strategy and Vision in place	S				FTSU vision and strategy approved by Trust Board in Sept 2020 and delivery is overseen by People Management Group and People Committee		X	
Freedom to Speak Up function established with dedicated Guardian in place	R				Temporary additional resource in place, but further permanent resource through Deputy and Champions required		X	
IT software package to record FTSU concerns	P				Case management solution being identified to support FTSU case tracking and reporting	X		
Policy framework in place (EDI, Dignity at Work, Raising Concerns)	P				Approved by PMG and available on intranet.		X	
Leadership and Management Development Programmes in place (paused during COVID-19 and challenges in organising new meetings	P				Kings Fund and Matron Development programme now in place.		X	
Board visibility through Board visits and Chairman and CEO monthly TeamTalks	P				Executive and Board visibility assessed through staff survey and Culture diagnostic review.		X	
Inclusion of BAME Recruitment Inclusion Specialists (RIS) on panels at Bands 8a+	R				Percentage of 8a+ panels that include a RIS monitored DI Dashboard	X		
Software system (Selenity) in place to manage employee relations data	S				Selenity implemented on 22 February 2021	X	X	
OD team established and posts recruited into	P				Divisional OD plans will be developed and signed off by site divisional teams		X	

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR8	**We fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity because our staff are not empowered to deliver to their best and do not feel safe to raise concerns**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Current leadership programme does not cover all leaders within the Trust	Develop Leadership skills programme for all team leaders, leadership programme for consultants and medical staff Management fundamentals programme for all staff has been outlined and is currently in design phase, implementation planned for May 2022. Leadership programme for Consultants and Medical staff is in design phase.	~~Mar 2022~~ May 2022	
Staff do not feel safe to raise concerns and lack confidence that actions will be taken where concerns are raised, and concerns raised through FTSU take too long to investigate / address	New Group-side FTSU policy to be developed by end Q2 2022/23 based on new national policy framework published in late June 2022. FTSU Charter and Raising Concerns triangulation group to be launched in Q2 2022/23. August 2022 is the Big 5 'speaking up, speaking out' month.	September 2022	
Produce Equality Delivery System (EDS2) report	The Trust is required to produce and publish a summary of our EDS2 implementation.	Mar 2023	

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Risk Appetite / Tolerance	**LOW**	Due to concerns regarding quality and diversity in our workforce, we have a low appetite for risks relating to workforce. However, in relation to developing future roles and recruitment and retention strategies our risk appetite is higher

Assurance Committee	**People Committee**
Exec Review Group	People Management Group
Executive Lead(s)	Group Chief People Officer
Date last Reviewed	10 June 2022

Current risk and assurance assessment

Risk score:
The risk score was decreased to a score of 16 (4C x 4L) in May 2022 following the Government's decision to revoke the Vaccination on Condition of Deployment (VCOD) regulations. There has been partial completion on a number of gaps in controls and assurances, however several remain open for completion in the new financial year. A new risk on the Corporate Risk Register has been opened in relation to Disclosure and Barring Service checks for staff.

Assurance rating:
An assurance rating of 'partial' was agreed by People Committee for Q1 2022/23.

Changes since last quarter:
No changes to risk scores or assurance ratings proposed at Q1 2022/23.

Gaps in control and assurance addressed year-to-date:
During 2021/22 the risk has been mitigated by the completion of a number of identified gaps in controls:

- The Workforce Strategy was reviewed and refreshed, with an implementation plan reviewed and communicated to PMG and WEC;
- The King's Fund leadership programme for Deputy General Managers and Service Managers has been delivered
- The matron and senior clinical leaders programme has been delivered;
- Divisional workforce plans have been developed and are due to be circulated in April 2022;
- The governance process has been established for extended roles – an ACP Steering Group has been established and approval given for a Chief Physician Associate;
- Revised Apprenticeship Plan has been agreed and approved at PMG.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2021/22
Q1	16 (4c x 4l)	Partial	⟷	20 = 4(C) x 5(L)	12 = 4(c) x 3(l)
Q2					
Q3					
Q4					

Emerging risks

- Staff remote working requirements
- Scaling back of HEE funding
- Establishment of clear governance arrangements for SWL Recruitment Hub (SLAs, KPIs)
- Risk against recruitment targets linked to continuing pressures experienced by staff leading to sickness and subsequent leavers

Future opportunities

- Further collaboration with SWL ICS and the Acute Provider Collaborative
- Development of different roles
- Links to University – opportunity to develop more 'in-house' training / courses with the university, cost effective, accredited
- Apprenticeships

Outstanding care every time

Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Workforce Strategy in place and approved by the Trust Board	S				Refreshed workforce strategy reviewed by WEC and Board		X	
Workforce strategy implementation plan	S				Update on workforce strategy implementation submitted to PMG and people Committee on a quarterly basis		X	
Education Strategy in place and approved by the Trust Board (Dec. 2019)	S				Education strategy implementation progress report to People Committee quarterly		X	
Education implementation plan	S				Monthly Strategy group meeting to monitor progress with all key stakeholders		X	
Development of new roles (i.e. ACPs) to help fill the gaps in vacancies	S				Workforce report to PMG and People Committee		X	
Advanced Clinical Practitioner Working Group established	R				Working group reports quarterly to PMG		X	
Recruitment open days for healthcare assistants and nursing now run by the Recruitment Hub	S				Quarterly report received from Recruitment Hub.		X	X
Appraisal training sessions / ad hoc training in place	P				Training completion log in Education Centre booking system		X	
New compliant (section 1 update) contracts of employment templates on TRAC	S				New contract uploaded that is being issued to new starters (from 01/10/2020)	X		
Performance and Development Review (Appraisal) guidance reviewed and in place. Totara system upgraded	P				Appraisal completion monitoring via ESR, appraisal training available for all appraisers. PDR system transformation programme	X		
CPD funding system process	R				Funding established for NMAP staff. Progress review submitted to PMG and WEC		X	
Apprenticeship Strategy	R				Apprenticeship plan reviewed and approved at PMG		X	
Disciplinary policy in place which includes 'Dido Harding' approach. Staff trained on the new approach to disciplinary cases	S				Policy in place and staff trained to support (completed Nov 2020)		X	
Flexible Working Policy/procedure implemented	S				On intranet, available to staff.		X	
Process to keep records for honorary contracts	S				New process established and list of honorary contract holders now reconciled with ESR	X		

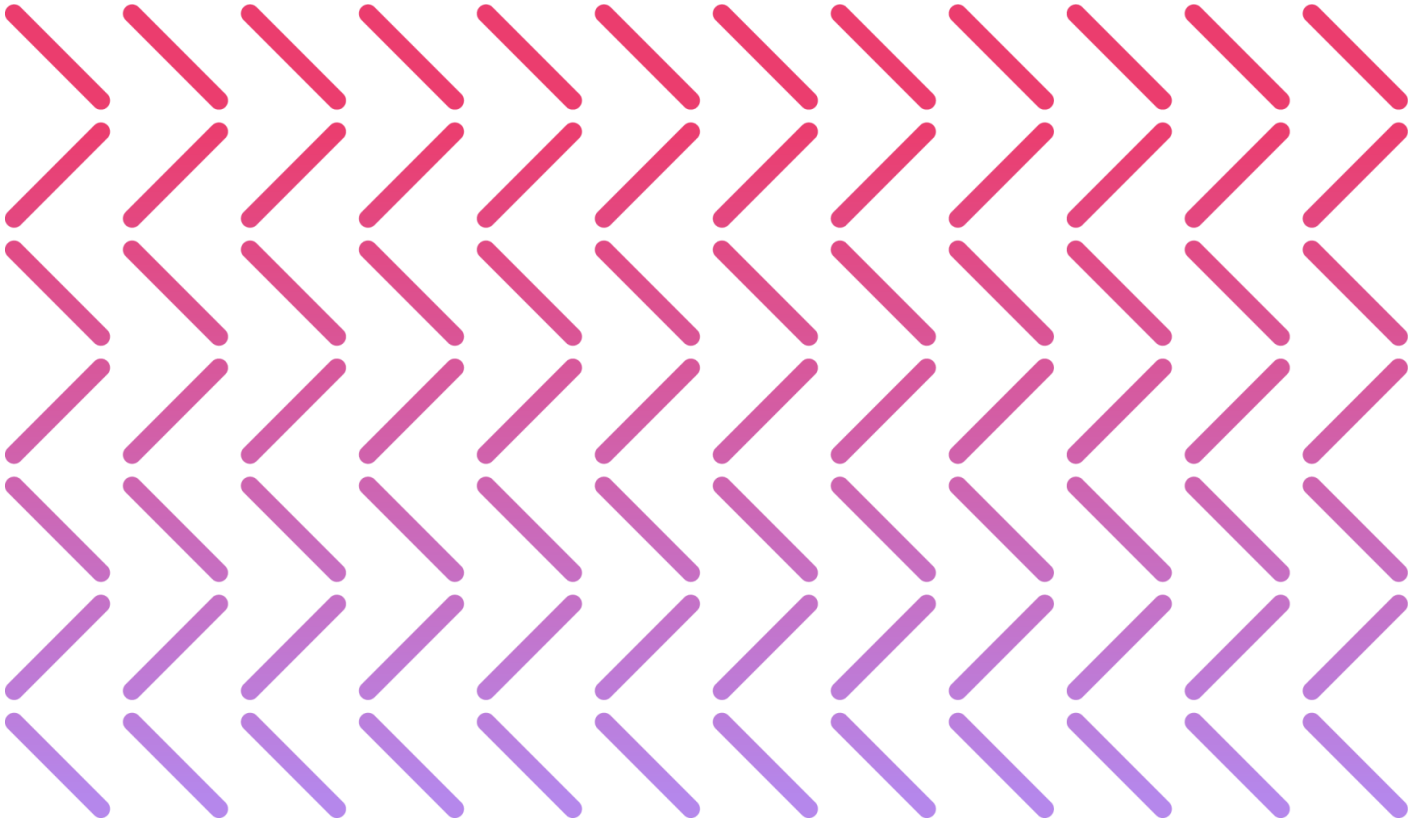
Strategic Objective	Champion Team St George's	*Corporate Objective:*	Culture
SR9	**We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Trust-wide workforce plan that sets out annual recruitment requirements	Divisional workforce plans to be produced by HR Business Partners and these will lay out clear workforce planning. Workforce plans being devised - currently being reviewed Active discussions are underway in divisions, supported by HR Business Partners to land divisional workforce plans in April 2022.	~~Mar 2021~~ ~~Apr 2021~~ ~~Aug 2021~~ May 2022	
Governance process for existing extended roles – ACPs and PA	Deploy new roles on relevant patient pathway – for ACPs and PAs Delayed due to 2nd Covid surge. Roles have been deployed. Appropriate governance has now been put in place. The ACP Steering Group approves training posts and JDs. Mapping ACP roles with the national framework, to ensure they meet HEE standards and to support in accessing accredited modules if necessary. Developing the Physician Associate Workforce for the Future was presented at PMG in January 2022 and agreement was given to recruit a Chief PA at 8b. Consultant Job plans are being reviewed to ensure appropriate clinical supervision for PAs and an education programme/CPD budget - applied for WFD funding from ICS to support partial CPD requirements	~~Mar 2021~~ ~~Jul 2021~~ ~~Sept 2021~~ May 2022	
Structured identification and development of new roles required to deliver patient care	Develop governance process for the identification of new roles and required funding. On-going identification of new roles and development governance process for the new roles identified. Identification of new roles included in divisional workforce plans to be circulated in April 2022. Central governance of newly established roles will form part of the wider workforce plans for the Deputy CPO to coordinate.	~~Mar 2021~~ ~~Sept 2021~~ July 2022	
International Recruitment Strategy for hard to recruit to posts	HRBPs to identify hard to recruit to posts . ACPW - Develop an International Recruitment Strategy working with SWL APC Recruitment Hub Delay due to competing interests post-Covid surge. International recruitment strategy to be included as part of the corporate workforce plans to be circulated in April 2022.	~~Mar 2021~~ ~~Sept 2021~~ May 2022	
Trust-wide workforce plan that sets out education & development needs to upskill existing and future workforce	Develop Trust-wide workforce plan that sets our Education & Development needs: HRBPs to Conduct Training Needs Analysis for each division by staff group; *Deliver advanced leadership programme*; Develop programme of blended on-line/face-to-face training Delayed due to capacity issues. HRBPs not completed TNA due to operational pressures, the education team will conduct a TNA for 2022/23, working with the HRBPs to develop plans for divisions.	~~May 2021~~ ~~Sept 2021~~ May 2022	
No minimum CPD funding allocated for non-NMAP staff	Include the CPD funding for non-NMAP into the 2021/22 business planning process Partial funding secured – currently reviewing for 2022/23 requirements. Bid was reviewed by PMG in March 2022 and to be reviewed by finance as part of 2022/23 business planning process.	~~Jul 2021~~ Mar 2022	
Senior leadership that reflects the diversity of the workforce	Develop inclusive talent management, succession planning and career planning pathways. Further embed fair and equitable recruitment & selection process at senior level (further intervention over and above a RIS on every recruitment panel is needed. Leadership and talent management lead post approved (band 8b) - to be advertised. Unsuccessful in appointing, therefore will be advertised again.	~~Oct 2021~~ ~~Mar 2022~~ Aug 2022	
Inadequate ICT infrastructure, hardware and software to access on-line learning	Established Education Delivery IT (EDIT) Group to review current position on training delivery technology, future design and gap analysis. The group includes representatives from IT. 2022/23 review is being planned. Group has been established. Premises are a challenge, and therefore capital plans are being reviewed.	~~Oct 2021~~ Dec 2022	

Outstanding care every time

Strategic Objective 6: Develop tomorrow's treatments today
Strategic Risk SR10

SR10:
Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation



Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration

SR10	Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation

Risk Appetite / Tolerance

HIGH	We have a high appetite for risks in this area in order to pursue research and innovation

Assurance Committee	**Quality Committee**
Executive Group	Patient Safety and Quality Group
Executive Lead(s)	Group Chief Medical Officer
Date last Reviewed	23 June 2022

Current risk and assurance assessment

Risk score:
The current risk score for SR10 of 9 continues to reflect the level of risk in relation to research, which balances the strong progress on Covid research against the impact of the pandemic on non-Covid research and the continuing absence of clarity on funding.

Assurance rating:
We have considered whether the assurance rating can be upgraded. While the assurance rating is "good", it is not considered to yet meet the requirements of "substantial" given the impact of Covid and the limitations on the Trust's control environment to mitigate to the risk to non-Covid research.

Changes since last quarter:
No changes are proposed to the overall risk score or to the assurance rating

Gaps in control and assurance addressed year-to-date:
Three actions to address identified gaps in control and assurance were due for completion in Q3 2021/22. The Translational & Clinical Research Institute (TACRI) is fully functioning and this action has been removed. The other two actions have been deferred for completion in December 2022. Appointing clinical academics is dependent on the Trust research strategy being fully funded – this is not yet confirmed and is being considered in the business planning process. The set up of a research data warehouse has been stalled pending the appointment of a contractor for the data warehouse – now that Bedrock have been appointed, work will progress on the research component.

Overall SR Rating – Quarterly Scores

Period 2022/ 2023	Risk Score	Assurance Strength	Change (last reporting period)	Inherent Risk Score	Target Risk Score For 2022/23
Q1	9 (3c x 3l)	Good	⟷	16 = 4(c) x 4(L)	6 = 3(c) x 2(l)
Q2					
Q3					
Q4					

Emerging risks

- Restrictions on funding/ investment to extend research activities, with consequent inability to exploit research opportunities in full
- Alignment of St George's and St George's University research priorities recognised as a risk in the Research Strategy
- Reduced availability of National Institute for Health research funding

Future opportunities

- National Institute for Health Research call for core Clinical Research Facility funding – awaiting outcome of application
- Opportunity for a greater research leadership role in SW London / partnership with other Acute Provider Collaborative Trusts
- Build on current profile related to Covid-19 research activity/ studies
- Develop closer collaboration between St George's and St George's University

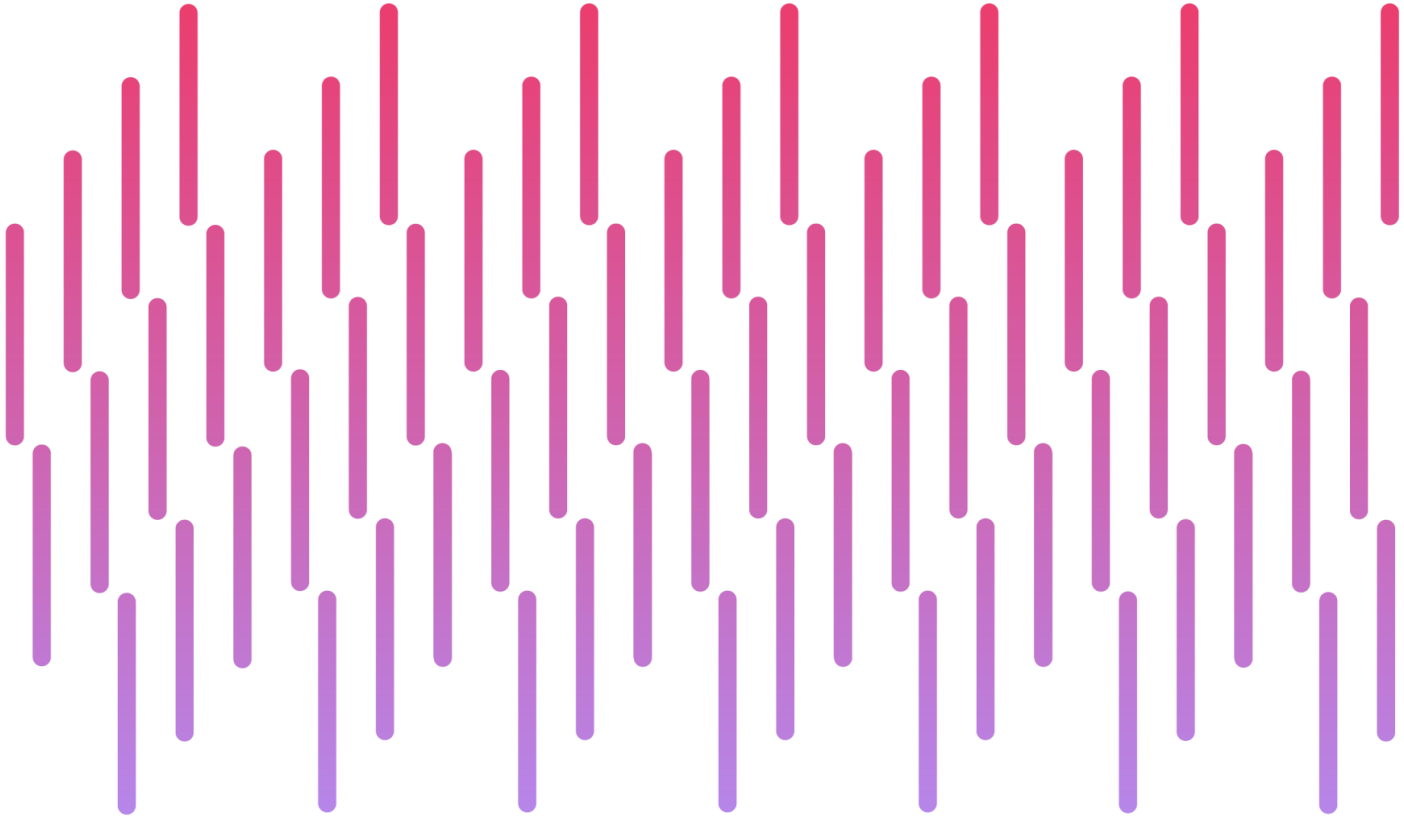
Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Key risk controls in place	Control effectiveness				Key sources of assurance	Lines of Assurance (positive / negative)		
	Q1	Q2	Q3	Q4		1	2	3
Research Strategy 2019-24 : approved by the Trust Board in December 2019 and supported by an implementation plan for the research strategy	S				• Increased numbers of clinical research studies led from St George's	X		
Partnership between St George's and St George's University London	S				• Partnership in place. TACRI and all four Clinical Academic Groups, which are joint Trust/University structures, have been set up. Reports from CAGs due to Joint Strategy Board in March 2022.	X	X	
Key role in south London Clinical Research Network (chaired by CEO)	S				• Leadership positions in the Clinical Research Network - St George's CEO now chairs the CRN Partnership Board.		X	X
Implementation of process of horizon scanning clinical studies, including 'easy win' studies to balance portfolio against lower recruiting more intensive studies	S				• We have increased the numbers of patients recruited to clinical trials, which doubled over 3 years.	X	X	
Regular research resource and portfolio review meetings with research teams	S				• JRES holds regular meetings with research teams to review patient recruitment and troubleshoot any problems.	X		
Joint Research and Enterprise Services review and ratify (with researchers) all study targets and resources required	S				• There is annual target setting process for patient recruitment which is monitored and supported by JRES	X	X	X
Translational and Clinical Research Institute (TACRI) Steering Committee set up	S				• Steering Committee in place and reports to Patient Safety Quality Group and QSC	X	X	
Funding to implement 2019-24 research strategy approved for 2021/22, but not yet for 2022/23	G				• £200K funding to implement the research strategy agreed. Statistical support for TACRI commenced, along with 7 fellowships for research nurses. We await the outcome of the 2022/23 funding request.		X	
Four Clinical Academic Groups formerly established	S				• Four CAGs have been established, and a CAG Director has been appointed for each.		X	

Strategic Objective	Develop tomorrow's treatments today	*Corporate Objectives 2021/22:*	Collaboration
SR10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**		

Gaps in controls and assurances	Actions to address gaps in controls and assurances	Complete by (date)	Progress
Few clinical academics - Many areas of Trust activity are not reflected in St George's University London research	**Seek investment to allow more clinical academic appointments** Investment will be needed from the Trust if new clinical academic posts are to be appointed (or new Trust consultants with protected time for research). Investment in the research strategy of £500K has been requested for 2022/23 and is currently been considered as part of business planning processes.	~~Dec 2021~~ Dec 2022	
Poor research IT infrastructure	**Seek investment /work with IT to set up research data warehouse** There is interest in a data warehousing project from both Trust and SGUL researchers and we have held initial discussions with Trust IT. A group comprising interested researchers and Trust IT has been set up to progress this.	~~Dec 2021~~ Dec 2022	

Appendix 1: Operational risks linked to strategic risks



Operational risks linked to Strategic Risk 1

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 1	**Our patients do not receive safe and effective care built around their needs because we fail to build and embed a culture of quality improvement and learning across the organisation**			**20**	**16**
Covid-19 - exposure	COVID-2051	Risk of exposure to Covid-19 virus	Feb 2020	**20 (5x4)**	**15 (5x3)**
Covid-19-wait too long (2)	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR3)	Apr 2020	**20 (4x5)**	**12 (4x3)**
Covid-19-wait too long (1)	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR3)	Apr 2020	**20 (4x5)**	**12 (4x3)**
7 Day Service Standards	MD1118	Failure to comply with 4 standards of the Seven day Service due to resource limitation and/or lack of defined operating model	Nov 2016	**15 (3x5)**	**12 (3x4)**
Infection control	CN2050	C Diff; MRSA; MSSA; E.Coli	Mar 2020	**12 (3x4)**	**9 (3x3)**
Covid-19-Fit test	COVID-2106	Lack of fit test for FFP3 masks	Apr 2020	**12 (4x3)**	**8 (4x2)**
Learning from incidents	CN1166	Failure to learn from incidents	Nov 2016	**16 (4x4)**	**8 (4x2)**
Deteriorating patients	MD1527	Staff fail to recognise, escalate and respond appropriately to the signs of a deteriorating patient. This may happen because the Early Warning Score is inaccurately recorded or the escalation process is not applied correctly	Dec 2016	**16 (4x4)**	**8 (4x2)**
Learning from complaints	CN2009	Failure to learn from complaints	Dec 2019	**16 (4x2)**	**8 (4x2)**
Covid-19-PPE	COVID-2107	Lack of PPE to effectively manage exposure to Covid-19 virus	Apr 2020	**20 (4x5)**	**4 (4x1)**

Operational risks linked to Strategic Risk 2

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 2	**We are unable to provide outstanding care as a result of weaknesses in our clinical governance**			20	**12**
Compliance with the CQC regulatory framework	CN-1179	Failure to comply with the CQC regulatory framework and deliver actions in response to CQC inspections may prevent the Trust achieving an improved rating at our next inspection	Jan 2017	20 (5x4)	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	**12 (4x3)**
Mental capacity Act	CN751	Failure to comply with Mental Capacity Act (MCA)	Jun 2016	16 (4x4)	**12 (4x3)**
Discharge	MD2052	Non-compliance with the eDischarge Summary Standard	Mar 2020	16 (4x4)	**12 (4x3)**
Improving the quality of clinical governance	CN-2056	There is a risk that we may not improve the quality of clinical governance following the external reviews of mortality monitoring & MDT and clinical governance in a timely manner which may have an adverse impact on patient care	Sep 2019	16 (4x4)	**12 (4x3)**
Cardiac surgery service – patient safety impact	CVT-1660	There is a risk that we may not make effective improvements to patient safety following the second NICOR mortality alert for cardiac surgery	Sep 2018	16 (4x4)	**4 (4x1)**
Learning from deaths	MD1119	Variation in practice in M&M / MDT meetings may mean we fail to learning from deaths and fail to make improvement actions to prevent harm to patients	Nov 2016	**8 (2x4)**	6 (2x3)

Operational risks linked to Strategic Risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 3	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**20**	**20**
Network outage	CRR-1395	Infrastructure - Risk of further major network outages due to out-dated, unreliable, and prone to failure network, as a result of a lack of investment and maintenance in the Trust's ICT Network Infrastructure	Sec 2017	25 (5x5)	20 (5x4)
ICT Disaster Recovery Plan	CRR-803	In the event of an ICT disaster, there is a RISK this would result in delays or a complete failure in the Trust's ability to recover its ICT systems.	Feb 2011	25 (5x5)	20 (5x4)
Emergency care 4hr operating standard	ED-2449	Failure to deliver and sustain the 95% Emergency Care Operating Standard	Jan 2022	25 (5x5)	20 (5x4)
Patient flow	COO-2393	Risk of inadequate patient flow in the Trust (and across the health care system) for emergency admission	Nov 2021	25 (5x5)	20 (5x4)
Virtual by Design	IT-2157	There is a risk that IT Audiovisual/infrastructure are not met by IT resources, impacting on patient care	Sep 2020	20 (4x5)	16 (4x4)
Telephony	CRR-1292	Infrastructure - Potential failure of the Trust's central telecoms system (ISDX) (1), radio tower system (DDI) (2), and/or VoIP platform (500 handsets) (3) due to aged telecoms infrastructure	Jul 2017	20 (5x4)	16 (4x4)
Data Warehouse/ Information Management Fragmentation	CRR-1312	Information - Risk of poor daily operational performance reporting due to difficulties to retrieve data stored on multiple storage	Aug 2017	20 (4x5)	16 (4x4)
Wrong blood in tube	RHO-1626	Misidentification of patient or of the blood sample at venepuncture for transfusion samples, leading to wrong blood in tube (WBIT).leading to ABO incompatible blood transfusion	Aug 2018	20 (5x4)	15 (5x3)

Operational risks linked to Strategic Risk 3

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 3 (continue)	**Our patients do not receive timely access to the care they need due to delays in treatment and the inability of our technology and transformation programmes to provide accessible care built around our patients' lives**			**25**	**20**
Management of RTT	COO-2371	Failed to meet the constitutional standard of 92% of patients being treated within 18 weeks from referral due to COVID-19 and insufficient capacity	July 2020	20 (4x5)	**12 (4x3)**
Exposure to Cyber or Malware attack	CRR-0013	Infrastructure - Risk of potential successful malware / cyber attack due to weakness in the ICT infrastructure. This could lead to loss of data and operational disruption	Apr 2016	20 (4x5)	**12 (4x3)**
Fragmented Clinical Records	CRR-1398	Unavailability of all the correct and up to date clinical information at point of care due to fragmented patient records as a consequence of: Cerner implementation, multiple clinical system running in parallel but separate from Cerner,	Dec 2017	20 (4x5)	**12 (4x3)**
Diagnostic findings	MD1526	Acting on diagnostic findings	Jul 2016	16 (4x4)	**12 (4x3)**
7 day services	MD1118	Failure to be compliant with 4 of the Seven Day Services clinical standards	Nov 2016	15 (3x5)	**12 (3x4)**
Paediatric ECHO delivery	CCAG-1980	Inability of safely provide a paediatric ECHO service at St Georges Hospital	Nov 2019	20 (4x5)	**9 (4x2)**
Covid-19-wait too long	COVID-2105	Non Covid-19 patients not known to the Trust wait too long for treatment (patients group B) (also see SR1)	Apr 2020	20 (4x5)	**Close**
Covid-19-wait too long	COVID-2104	Non Covid-19 patients, known to the Trust, wait too long for treatment (patient group A) (also see SR1)	Apr 2020	20 (4x5)	**Close**

Operational risks linked to Strategic Risk 4

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 4	**As part of our local Integrated Care System, we fail to deliver the fundamental changes necessary to transform and integrate services for patients in South West London**			16	12
Children's cancer services		Children's cancer services - risk of losing service as part of service reconfiguration across London		20 (5x4)	15 (5x3)
Devolution of specialised commissioning	STR-2220	There is a risk that the devolution of NHSE specialised commissioning is effected in a way that conflicts with the Trust's strategy to be the tertiary centre for SWL and Surrey	Feb 2021	16 (4x4)	**12 (4x3)**
Other providers' strategies conflicting with Trust Strategy	CRR-1899	There is a risk that other acute providers in SWL will pursue clinical/commercial relationships with other tertiary providers that pose a strategic threat to SGUH	Aug 2019	15 (5x3)	**10 (5x2)**
Disagreement on future of QMH	STR-2311	There is a risk that the Trust and system partners (CCG, Kingston) are unable to agree on future use of QMH	Aug 2021	**9 (3x3)**	6 (3x2)

Operational risks linked to Strategic Risk 5

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 5	We do not achieve financial sustainability due to under delivery of cost improvement plans and failure to realise wider efficiency opportunities			25	20
Managing Income & Expenditure in line with budget	CRR-1411	Risk the Trust is not able to manage income and expenditure against agreed budgets to delivery the financial plan.	Dec 2017	25 (5x5)	20 (5x4)
Managing an effective financial control environment	CRR-0028	Risk of not meeting statutory obligations, prevent fraud, mismanagement of funds or inappropriate decision making by Trust officers due to ineffective financial systems and processes	Oct 2016	25 (5x5)	20 (4x5)
Identifying and delivering CIPs	CRR-1865	Risk that the Trust doesn't have sufficient capacity and capability to deliver CIPs at the level required to hit the financial plan.	Apr 2019	25 (5x5)	25 (5x5)
Future cash requirements are understood	CRR-1416	Risk that future cash requirements are not understood	Dec 2017	20 (5x4)	15 (5x3)
Manage commercial relation with non-NHS organisations	Fin-1856	Risk that the Trust does not have sufficient capacity, or skills to manage commercial relationships with non-NHS organisations procuring services from the Trust.	May 2019	16 (4x4)	12 (4x3)
Processes to manage cash and working capital	CRR-1417	Risk that the Trust does not have up to date processes to manage cash and working capital	Dec 2017	25 (5x5)	25 (5x5)
Understanding cost structures	Fin-1372	A risk that we do not understand our current cost and performance baseline and structures, or benchmark ourselves against others in this area to identify efficiencies and improvements.	Nov 2017	15 (5x3)	9 (3x3)
Maintaining a five year forward view	CRR-1413	The Trust has insufficient capacity to develop a five year long term financial plan that is aligned to an agreed clinical strategy.	Dec 2017	16 (4x4)	9 (3x3)
Maintaining an effective procurement environment	Fin-1083	Risk the Trust has insufficient capacity and capability to ensure best value is achieved on all procurement.	Oct 2016	15 (3x5)	9 (3x3)
Managing within new contract forms (block contracts)	Fin- 1858	There is a risk that the Trust could be financially impacted by a failure to manage performance inline with new contract models, specifically a block contract.	May 2019	12 (3x4)	9 (3x3)
Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London	Fin-1857	Risk that the Trust could be financially penalised due to non-delivery of control totals within South West London. It is unclear within planning guidance what the impact of other organisations within the South West London patch not hitting control totals will be on the organisations.	May 2019	12 (3x4)	9 (3x3)
Unsupported finance and procurement system	Fin-1083	A risk that the Trust has an unsupported finance and procurement system.		12 (4x3)	8 (4x2)
Base Budget	NEW	Risk that the base budget does not accurately reflect the opening run rate of expenditure	June 2022	12 (3x4)	9 (3x3)
Budgetary Control	NEW	Risk that budgetary control measures are insufficiently robust	June 2022	12 (3x4)	9 (3x3)
Elective Recovery Fund	NEW	Risk that the trust cannot deliver 104% of value weighted activity	June 2022	25 (5x5)	20 (5x4)

Operational risks contributing to Strategic Risks 6

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 6	We are unable to invest in the transformation of our services and infrastructure, and address areas of material risk to our staff and patients, due to our inability to source sufficient capital funds			25	20
Funding for 5 year capital plan	1414	The Trusts does not have funding sources confirmed to deliver years 2 through to 5 of the 5 year capital plan.		25 (5x5)	20 (5x4)
Funding for current year capital plan	2451	The Trusts does not have funding sources confirmed to deliver the next 1 year of the capital plan		12 (3x4)	20 (5x4)
Identification of all capital funding streams	NEW	Trust is awaiting confirmation of year 2 funding for the TIF ITU expansion	June 2022	20 (5x5)	20 (5x4)
Planned over commitments	NEW	Need for development of plans to manage planned over commitments	June 2022	20 (5x5)	20 (5x4)

Operational risks linked to Strategic Risk 7

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 7	**We are unable provide a safe environment for our patients and staff and to support the transformation of services due to the poor condition of our estates infrastructure**			**20**	**16**
Inability to address infrastructure backlog maintenance to maintain safe site	CRR-0008	Inability to address infrastructure backlog maintenance to maintain safe site due to lack of capital	Jul 2016	**25 (5x5)**	**20 (4x5)**
Risk of fire starting in Lanesborough Wing developing into a major fire	EF2036	Risk that an undetected and immediately extinguished fire could develop into a major fire resulting in area evacuation	Feb 2020	**25 (5x5)**	**20 (5x4)**
Lack of UPS/IPS power supplies	EF2061	Lack of UPS/IPS power supplies	Mar 2020	**20 (5x4)**	**15 (5x3)**
Data Centre	CRR-810	Risk that a fire, flood, power failure in the Data Centre could cause loss of data due to having a single data centre hosting all on-site critical systems	Mar 2014	**20 (5x4)**	**15 (5x3)**
Electrical Infrastructure - Risk of non-compliance	CRR-1311	Risk of electrical non-compliance with Electricity at Work Regulations and BS7671 due to lack of regular testing	Aug 2017	**16 (4x4)**	**12 (4x3)**
Bacterial contamination of water supply	CRR-0016	Risk from exposure to potential pathogenic bacteria in water	May 2014	**20 (5x4)**	**12 (4x3)**
Cardiac Catheter Labs breakdowns	CCAG-1025	Cardiac Catheter Labs breakdown /failure due to old equipment/ infrastructure	Sep 2016	**20 (4x5)**	**8 (4x2)**

Operational risks linked to Strategic Risk 8

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 8	Our staff are not empowered to deliver to their best and do not feel safe to raise concerns because we fail to build an open and inclusive culture across the organisation which celebrates and embraces our diversity			20 (4x5)	16 (4x5)
Organisational culture	HR-2178	There is a risk that we fail to achieve a significant shift in culture to support the delivery of the Trust strategic objectives	Sep 2020	20 (4x5)	16 (4x5)
Diversity and Inclusion	HR-1967	There is a risk that we are unable to deliver our Diversity and Inclusion Strategy or that it does not have the required impact	Jul 2019	20 (4x5)	16 (4x4)
Raising Concerns	HR-1978	There is a risk that our staff a) don't know how to raise concerns at work b) don't know who to raise concerns with c) are not confident the concerns will be properly address and d) don't feel safe in raising concerns	Nov 2019	20 (4x5)	16 (4x4)
Bullying and Harassment	HR-881	There is a risk that our staff continue to report high levels of bullying and harassment compared with peers and that we have not taken adequate measures to address this	May 2010	20 (4x5)	16 (4x4)
Effective Engagement	HR-1364	There is a risk that we fail to engage effectively with our staff	Apr 2016	15 (3x5)	12 (3x4)
Organisational Development	HR-1360	There is a risk that we do not ensure that our senior managers are developed to have the right leadership skills to be able to deliver our vision of outstanding care every time	Nov 2017	15 (3x5)	12 (3x4)
Recognise good practice	HR-1361	A risk that we do not recognise success or good practice amongst our workforce.	Nov 2017	15 (3x5)	12 (3x4)

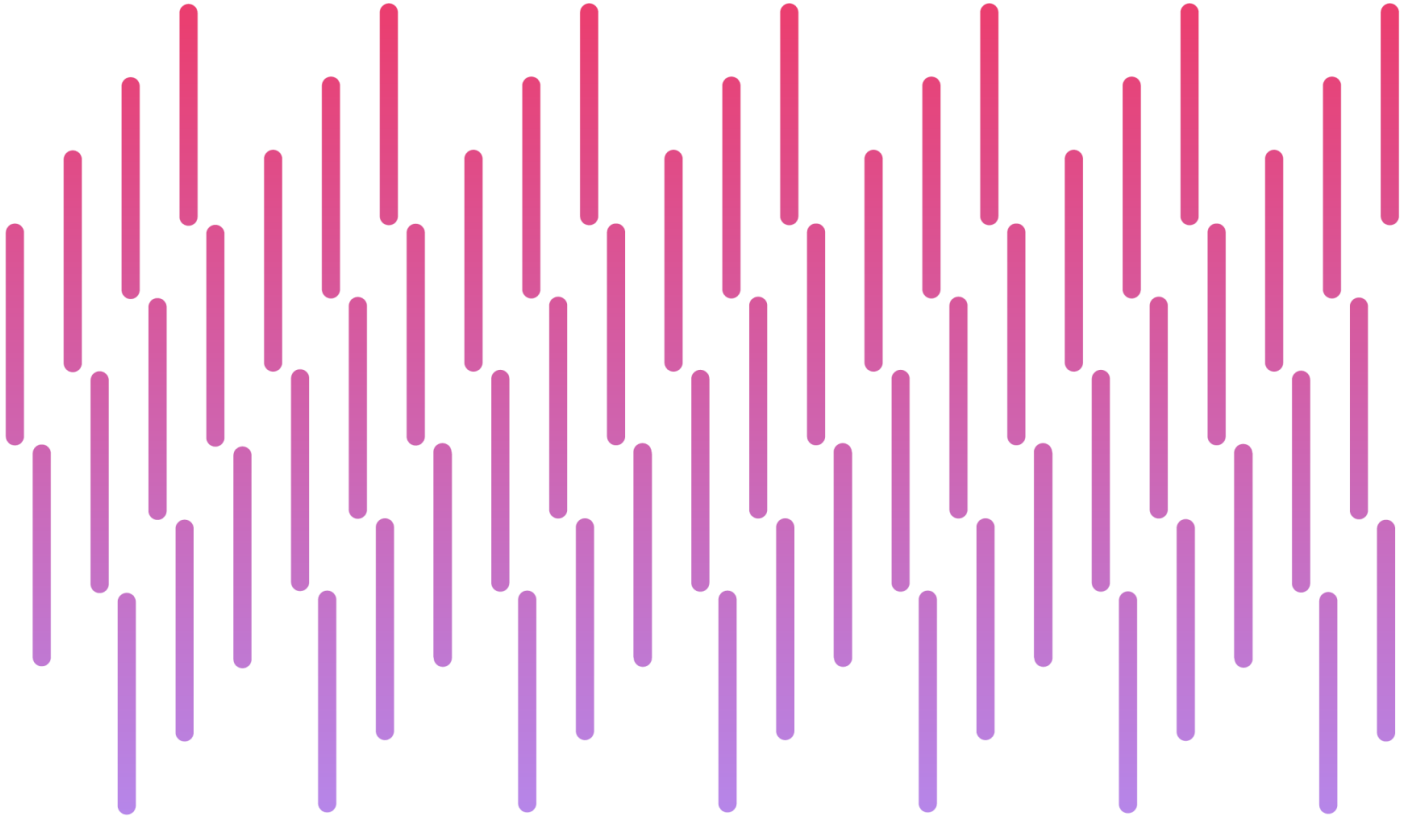
Operational risks linked to Strategic Risk 9

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 9	We are unable to meet the changing needs of our patients and the wider system because we do not recruit, educate, develop and retain a modern and flexible workforce and build the leadership we need at all levels			20	16
Junior Doctors vacancies	CRR-1684	There is a risk that we are unable to fill Junior Doctor rota vacancies, leading to rota gaps which may impact on patient safety	Oct 2018	20 (4x5)	16 (4x4)
Recruitment and Retention	CRR-0025	There is a risk that we fail to recruit and retain sufficient and suitable workforce with the right skills to provide quality of care and service at appropriate cost	Jan 2015	20 (4x5)	16 (4x4)
Disclosure and Barring Service Checks	NEW	Staff are working with vulnerable adults and / or children without the appropriate check of their criminal records	June 2022	20 (4x5)	16 (4x4)
High quality appraisals	HR-1363	Risk that we do not ensure all of our staff have a high quality appraisal.	Nov 2017	16 (4x4)	12 (4x3)
Health and Wellbeing	HR-2242	There is a risk that health and wellbeing is not embedded in the organisation.	Apr 2021	12 (3x4)	9 (3x3)
Education Strategy	HR-2179	Failure to deliver the Education Strategy due to potential lack of organisational engagement and financial constraints	Oct 2020	12 (3x4)	9 (3x3)
Workforce Strategy	HR-2038	There is a risk that the identified priorities in the Workforce Strategy do not produce the improvements or changes desired.	Feb 2020	12 (3x4)	9 (3x3)

Operational risks linked to Strategic Risk 10

Risk short form title	CRR Ref	Description	Open Date	Inherent Score	Current Score Jul 2022
Strategic Risk 10	**Research is not embedded as a core activity which impacts on our ability to attract high calibre staff, secure research funding and detracts from our reputation for clinical innovation**			16	9
The profile of research in SGHT being low	MD-1133	There is a risk that insufficient focus is given to research in SGHT. This could lead to a lack of investment in research, impacting on research delivery, income, reputation and ability to recruit and retain high calibre staff	Nov 2016	**15 (3x5)**	**12 (3x4)**
Clinical Research recruitment reduction	MD-1132	Risk of Clinical Research recruitment reduction. could result in a significant shortfall in overall (CRN and Commercial) recruitment and therefore reduction in research funding and income	Nov 2016	**12 (3x4)**	**9 (3x3)**
MHRA accreditation of the research department	MD-1405	There is a risk that the research department does not retain its MHRA accreditation due to poor infrastructure/ compliance	Dec 2017	**16 (4x4)**	**8 (4x2)**
Research partnership with St George's University	MD-1495	There is a risk that if research priorities are not aligned across SGUH and SGUL we will miss opportunities to translate academic research in to improved patient outcomes	Mar 2018	**12 (3x4)**	**6 (3x2)**

Appendix 2: Scoring the Board Assurance Framework
Risk Assessment & Assurance sources and descriptors



Outstanding care every time

Scoring the Board Assurance Framework

Risk Assessment and tracking of actions to address gaps in controls

Calculating Risk Scores

Risk Grading (Scoring)

	CONSEQUENCE INDEX			LIKELIHOOD INDEX*	
5	Catastrophic	Multiple deaths caused by an event; ≥£5m loss; May result in Special Administration or Suspension of CQC Registration; Hospital closure due to enforcement action; Total loss of public confidence	5	Almost Certain	No effective control; or ≥ 1 in 5 chance within 12 months
4	Major	Severe permanent harm or death caused by an event; £1m - £5m loss; Prolonged adverse publicity; Prolonged disruption to one or more Divisions; Extended service closure	4	Likely	Weak control; or ≥1 in 10 chance within 12 months
3	Moderate	Moderate harm – medical treatment required up to 1 year; £100K - £1m loss; Temporary disruption to one or more Divisions; Service closure	3	Possible	Limited effective control; or ≥ 1 in 100 chance within 12 months
2	Minor	Minor harm – first aid treatment required up to 1 month; £50K - £100K loss; or Temporary service restriction	2	Unlikely	Good control; or ≥ 1 in 1000 chance within 12 months
1	Insignificant	No harm; 0 - £50K loss; or No disruption – service continues without impact	1	Rare	Very good control; or <1 in 1000 chance (or less) within 12 months

*Use of relative frequency can be helpful in quantifying risk, but a judgment may be needed in circumstances where relative frequency measurement is not appropriate or limited by data.

Risk scoring matrix

L/C	1	2	3	4	5
5					
4					
3					
2					
1					

Calculating Strength of Controls

Strength of controls

Control Strength	Description
Substantial	The identified control provides a strong mechanism for helping to control the risk
Good	The identified control provides a reasonable mechanism for helping to control the risk
Reasonable	The identified control provides a partial mechanism for controlling the risk but there are weaknesses in this
Weak	The identified control does not provide an effective mechanism for controlling the risk

Scoring the Board Assurance Framework
Assurance sources and descriptors

Sources of Assurance

Sources of Assurance

Line of Assurance	First Line Assurance	Second Line Assurance	Third Line Assurance
Description	Care Group / Operational level	Corporate Level	Independent and external
Examples	Service delivery / day-to-day management Care Group level oversight Divisional level oversight	Board and Board Committee oversight Executive oversight Specialist support (e.g. finance, corporate governance)	Internal audit External audit Care Quality Commission NHSE&I Independent review Other independent challenge

Progress on actions to address gaps in control / assurance

Delivered	
On track to deliver to agreed timescale	
Slippage against agreed timescales (non-material)	
Progress materially off track	
Action not delivered to agreed timescale	

Calculating Ratings of Assurance

Assurance Levels

Level of Assurance	Description
Substantial	Governance and risk management arrangements provide substantial assurance that the risks identified are managed effectively. Evidence provided to demonstrate that systems and processes are being consistently applied and implemented across relevant services. Outcomes are consistently achieved across all relevant areas
Good	Governance and risk management arrangements provide a good level of assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are generally being applied and implemented but not across all relevant services. Outcomes are generally achieved but with inconsistencies in some areas
Partial	Governance and risk management arrangements provide reasonable assurance that the risks identified are managed effectively. Evidence is available to demonstrate that systems and processes are being applied but insufficient to demonstrate implementation widely across services. Some evidence that outcomes are being achieved but this is inconsistent across areas and / or there are identified risks to current performance
Limited	Governance and risk management arrangements provide limited assurance that the risks identified are managed effectively. Little or no evidence is available that systems and processes are being consistently applied or implemented within relevant services. Little or no evidence that outcomes are being achieved and / or there are significant risks identified to current performance